General practitioner responses to concerns about (possible) child maltreatment in England:

a mixed methods study

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Declaration

I, Jenny Woodman, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Abstract

Background: There is increasing recognition that GPs' responses to maltreatment-related concerns should include but go beyond referral to and joint-working with children's social care. However, the role of the GP in this area remains contentious and wider responses in general practice are not fully defined.

Aim: To describe and understand responses to concerns about child maltreatment in general practice in England.

Methods: I estimated the annual incidence of maltreatment-related codes in children's electronic primary care records (over time, by child characteristics) and estimated between-practice variation using a UK representative cohort of 1.5 million children from The Health Improvement Network (THIN) database. I also calculated prevalence estimates for 2010. I investigated other responses to maltreatment-related concerns through unstructured in-depth interviews with GPs (N=14), health visitors (N=2) and practice nurses (N=2) and observations of team meetings (N=4) in four practices in England. I undertook a development phase with 11 GP practices in England to prepare for the study proper and used literature reviews to drive my study design and contextualise my results. I aimed to increase the breadth and depth of my findings by adopting a mixed methods design (integrating quantitative and qualitative data).

Results: In 2010, the annual incidence of children with any maltreatment-related code was 9.5 (95%CI 9.3, 9.8) per 1000 child years, equivalent to a code entered in the record of 0.8% (95%CI 0.8, 0.8) of all children registered in 2010. I identified seven actions that GPs described taking in response to maltreatment-related concerns. GPs enacted responses through parents and other family members as well as children. From the GPs' perspective, strong relationships with parents and health visitors were prerequisites for responding to maltreatment-related concerns.

Conclusions: My findings challenge policy makers, professionals and researchers to rethink the GPs' role in responding to maltreatment-related concerns.

Acknowledgements

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This study would not have been possible without the GPs, health visitors and practice nurses who participated and spoke so frankly about their experiences of managing children and families. I am especially grateful to the GPs who acted as gatekeepers and shepherded me safely into their practices.

Collaboration and multidisciplinary working is at the heart of mixed methods research and I am very lucky to have had expert colleagues who have given their time generously. I would particularly like to thank: Irene Petersen and Nick Freemantle from UCL-Department of Population Health and Primary Care who welcomed me into their department and shared their statistical expertise with me; my GP collaborators Janice Allister (RCGP), Simon de Lusignan (University of Surrey) and Imran Rafi (RCGP) who helped me understand general practice and provided feedback at crucial points; and colleagues at the NSPCC who commented on my work. I feel privileged to have come into contact with so many talented and committed researchers, including the many that work with me at UCL-Institute of Child Health.

Thanks to my friends who have encouraged, listened and advised. Some of them have made the PhD journey themselves (Katie Harron, Wilhelmine Meeraus, Ivana Pribramska, Shema Tariq, Heather Bailey, Clare French, Chloe Parkin and Kathryn Oliver) and some not.

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List of publications arising from PhD work

Peer reviewed papers

The peer-reviewed papers are reproduced in Appendices 9.1 to 9.6:

1. Gilbert R, **Woodman J,** Logan S. Developing services for a public health approach to child maltreatment. *International Journal of Children's Rights* 2012;20(3):323-42.
2. Tariq S, **Woodman J.** Using mixed methods in health research. *JRSM Short Reports* 2013;4(6).
3. **Woodman J**, Allister J, Rafi I, de Lusignan S, Belsey J, Petersen I, et al. Simple approaches to improve recording of concerns about child maltreatment in primary care records: developing a quality improvement intervention. *Br J Gen Pract* 2012;62(600):e478-e86(9).
4. **Woodman J**, Freemantle N, Allister J, de Lusignan S, Gilbert R, Petersen I. Variation in recorded child maltreatment concerns in UK primary care records: a cohort study using The Health Improvement Network (THIN) database. *PLOS ONE* 2012;7(11):1-9.
5. **Woodman J**, Gilbert R, Allister J, Glaser D, Brandon M. Responses to concerns about child maltreatment: a qualitative study of GPs in England. *BMJ Open* 2013;3(12):e003894. doi: 10.1136/bmjopen-2013-94.
6. **Woodman J**, Gilbert R, Glaser D, Brandon M. Vulnerable family meetings: a way of promoting team working in GPs' everyday responses to child maltreatment? . *Soc. Sci.* Under review.
7. **Woodman J**, Brandon M, Bailey S, Belderson P, Sidebotham P, Gilbert R. Healthcare use by children fatally or seriously harmed by child maltreatment: analysis of a national case series 2005-2007. *Arch Dis Child* 2011;96(3):270-5.

Paper 6 (on vulnerably family meetings) is not included in the Appendices of this thesis as it is not yet accepted for publication (under review for a special child

protection edtion of Social Sciences Online). The work for paper 7 above (children seriously or fatally harmed from maltreatment) was undertaken as part of my PhD study but was ultimately excluded from my thesis due to space restrictions.

Book chapters

1. **Woodman J**, Gilbert R. The role of health services in responding to child maltreatment. In: Arnon Bentovim and Jenny Gray, editor. *Eradicating Child Maltreatment* London: JKP, in press (due out September 2014).

2. **Woodman J,** Gilbert R. Child maltreatment: moving towards a public health approach. In: Foyle G, V. N, editors. *Growing up in the UK II*. London: BMA, 2013.

Reports

1. **Woodman J**, Woolley A, Gilbert R, Rafi I, Allister J, De Lusignan S, et al. *The GP's role in responding to child maltreatment: time for a rethink?*. London: NSPCC, 2014.

Editorials

1. **Woodman J**, Rafi I, de Lusignan S, Child maltreatment: the role of general practice, *Br J Gen Pract*, in press (due September 2014)

Letters

1. **Woodman J**, Gilbert R. Proposed CPIS seems to run counter to best evidence. *BMJ* 2013;346:f504
2. **Woodman** J, De Lusignan S, Rafi I, Allister J, Gilbert R. GPs' role in safeguarding children. *BMJ* 2012;345:e4758

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Abbreviations

A&E	Accident and Emergency Department.
95% CI	95% confident intervals. The upper and lower confidence intervals represent the parameters for a range of values within which the true population estimate may lie. Confidence intervals are a way of quantifying the effects of random error (chance) that come from using a sample (not a whole population). All other things constant, if a study were repeated 100 times in different samples of the same population, 95/100 times the central estimate would fall within the bounds of the 95% CI.
CCGs	Clinical Commissioning Groups: groups of General Practices within a geographical area that work together to plan and design local health services in England by 'commissioning' or buying health and care services to meet local need. This system of commissioning services locally was set up under the Health and Social Care Act 2012 and CCGs largely replaced the function of Primary Care Trusts (PCTs). CCG boards are made up of GPs from the local area and at least one registered nurse, secondary care specialist doctor and member of the public. In 2013/14, there were 211 CCGs in England who were responsible for £65 billion of the £95 billion NHS commissioning budget. CCGs have a 'duty to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children'.[3]
CRN	Clinical Research Network: part of the National Institute for Health Research, aiming to provide the infrastructure that allows high-quality clinical research to take place in the NHS.

GMC	General Medical Council: The independent regulator for doctors in the UK which protect, promote and maintain the health and safety of the public by making sure that doctors follow proper standards of medical practice.
GP	General Practitioner: a family doctor who treats acute and chronic illnesses and provides preventive care and health education for all ages and all sexes. They have particular skills in treating people with multiple health issues and co-morbidities. See section 1.5.1, p.56 for a detailed description.
HV	Health visitor: a specialist nurse who supports and educates families from pregnancy through to a child's fifth birthday by, for example: offering parenting support and advice on family health and minor illnesses, conducting new birth visits which include advice on feeding, weaning and dental health, physical and developmental checks, and providing families with specific support on subjects such as post natal depression.
LCSB	Local Children's Safeguarding Boards: LSCBs were established by the Children Act 2004. Each locality has a statutory responsibility to each locality to have a LCSB. The LCSB ensues that all organisations working with children have safe practices and child protection procedures in place and provide training, advice and guidance.
MRC	Medical Research Council: the MRC receives money from the government to support research which aims to improve human health globally. Although government-funded, the MRC is independent in its choice of which research to support. They work closely with the Health Departments, the other UK research councils, industry and other stakeholders to identify and respond to the UK's health needs.

NICE	National Institute of Health and Care Excellence (NICE): an independent organisation that collates and accredits high-quality health guidance, research and information to help health professionals deliver the best patient care through NHS Evidence. NICE guidance is expected to be taken into full consideration by healthcare professionals and organisations when deciding on treatments for patients.
NHS	National Health Service: the publically funded healthcare system in England (primarily funded through central taxation). The services provide a comprehensive range of health services, the vast majority of which are free at the point of use for people legally resident in the country.
NSPCC	National Society for Prevention of Cruelty to Children: a UK charity aiming to prevent child maltreatment and reduce its recurrence and impact.
PCT	Primary Care Trusts: part of the National Health Service in England. PCTs were largely administrative bodies, responsible for commissioning primary, community and secondary health services from providers. Until 31 May 2011 they also provided community health services directly. Collectively PCTs were responsible for spending around 80% of the total NHS budget. Primary Care Trusts were abolished on 31 March 2013 as part of the Health and Social Care Act 2012, with their work taken over by Clinical Commissioning Groups.
RCGP	Royal College of General Practitioners: the professional body for GPs.
THIN database	The Health Improvement Network Database: a large clinical database containing primary care records for approximately 6% of primary care patients in the UK. Primary care notes are universally computerised with records made by the GP or nurse at the time a patient is seen, although other information from test results and letters is often added to the

computerised record outside the consultation, sometimes by clerical staff. The primary purpose of the primary care record is for clinical management of the patient by the primary care team, including the GP.

Glossary

This following section describes the way in which I have employed terms in this thesis.

Child maltreatment	Includes all forms of child abuse and neglect. The terms "child maltreatment" and "child abuse and neglect" are used interchangeably in this thesis.
Child in Need	Children who have been judged as "in need" by children's social care services in the UK, under section 17 of the 1989 Children Act.[4] Children in Need are defined as children who require supportive services to achieve a satisfactory level of health and development or those whose health and development will suffer without the provision of services. Under the Children Acts 1989 and 2004, statutory agencies (including health) have a responsibility to identify and respond to the needs of these children.[4 5]
Child Protection	Professional actions taken to protect children who have been judged by social care services as suffering or at risk of suffering significant harm due to child maltreatment, under section 47 of the 1989 Children Act.[4] The concept of significant harm revolves around establishing whether the child's health or development has been impaired or is likely to be impaired due to abuse or neglect, compared to what might reasonably be expected of another similar child.[6] Under the Children Acts 1989 and 2004, statutory agencies (including health) have a responsibility to identify and respond to the needs of these children. See section 1.4.1.1, p. 41 for a more detailed discussion.

Child Protection Plan	Child protection services are delivered via a Child Protection Plan, which is a written report agreed upon by a multidisciplinary 'core group' of professionals and parents/carers, led by a social worker. [6] The Child Protection Plan is based on the core assessment of the child and family and will contain details of services that are deemed necessary, realistic goals for measurable change in parental behaviour, child and parent interaction and/or child outcome and timescales for achieving those changes.[6] The core group of professionals have a statutory responsibility to undertake a review of the Child Protection Plan, the child and the family at least every six months. [6] Child protection services assessments and interventions are coercive. If parents or caregivers do not comply or insufficient progress is made, legal action can be initiated to remove the child and place him or her in local authority care.
Children's social care	Statutory agency with the responsibility of safeguarding children, young people and families, via preventative family support and child protection services, child placement, fostering, adoption, working with young offenders, children and young people who have learning or physical disabilities, or homeless, as well as support for families and carers. Children's social care are responsible for the provision of resources, training and support for those working in social care, including social workers.
General practice	The professional practice of GPs and the setting in which GPs deliver care.
GP practice or surgery	The building in which the primary healthcare team provide primary healthcare services to patients.

Primary healthcare team	The GP, practice nurse, health visitor and midwife.
Safeguarding	A term used in the 1989 Children Act and in subsequent policy to refer to professional actions to promote the welfare and wellbeing of all children, including child protection activity. See section 1.4.1.1, p.41 for a more detailed discussion of the terms “safeguarding” and “child protection”.

1 CHAPTER 1: Introduction, rationale and scope

Statement of authorship

I carried out all the work presented in this chapter, which has also been published as a book chapter and journal article, informed a letter to the editor of the British Medical Journal and a report which I wrote for the NSPCC.[7-10] The journal article is reproduced in Appendix 9.1.

1.1 Content and structure of Chapter 1

In this chapter, I present the background to my study and describe the service, policy and research context that generated my research questions. The work in this chapter is based on literature and policy reviews undertaken between September 2009 and October 2013.[1] The search strategies for the reviews can be found in Appendix 1.1. When selecting relevant literature, I focussed on key policy documents,[2] systematic reviews of research and investigations or reports that had been commissioned by government administration with the intention of shaping policy and/or GP (general practitioner) practice. I used the bibliographies of these high level documents to guide my reading of primary research studies.

I drew primarily on research conducted in English settings and policy documents, reports or investigations relevant to policy in England. I concentrated on documents and publications post 2000. This is the year of the high profile death of Victoria Climbié following abuse and neglect, which prompted a review of child protection in England and influenced the Green Paper 'Every Child Matters' and a whole policy agenda of the early 2000s.[11] Where there was a paucity of English research or where the international literature lent credence to that from English settings, I have cited literature from other UK countries or international literature.

My focus is on *professional responses* to child maltreatment and I touch on the wider epidemiological and social science literature about child maltreatment only where relevant.

[1] A series of systematic reviews were outside of the scope of this thesis.

[2] Key policy documents were defined as: statutory child protection and safeguarding guidance for all professionals or policy documents specifically pertaining to GPs.

1.2 What is child maltreatment?

Child maltreatment is a socially constructed concept describing situations where a person behaves or interacts in ways that seriously contravene societal norms relating to children, childrearing or childhood.[12] Our current societal norms include children's rights to live free from fear, violence and sexual exploitation, to be protected from physical and psychological harm, to attend school, to participate fully in society and to be supported to meet optimal health, development and growth.[13-15] This understanding of maltreatment as a breach of social norms extends beyond policy-makers and academics into the wider public. A study using in-depth interviews with 20 members of the public in England in 2013 reported that these members of the public had a deeply held belief that children are to be cared for, nurtured and protected. Participants understood child maltreatment to be a violation of this fundamental notion of childhood.[16]

Typically, the term "child maltreatment" refers to all forms of abuse and neglect in children under 18 years of age by a parent, caregiver or other adult, although results from large-scale surveys suggest that adults living in the family home are responsible for the vast majority of child maltreatment.[17 18]

Child maltreatment encompasses the subcategories of:

- Neglect
- Physical abuse
- Emotional abuse
- Sexual abuse

The World Health Organisation defines child maltreatment as:

> All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.[13 (p.9)]

Increasingly, it is being recognised that child maltreatment includes a range of severity that extends far into the "normal" population.[19-24] In this continuum model of maltreatment,[22] treatment of children ranges from the optimal to the severely abusive. Conceptualising maltreatment as one end of a continuum makes it clear that there is no natural or obvious cut-off where poor treatment or poor parenting of children becomes "maltreatment". The "grey area" in the middle of the spectrum can cause conceptual difficulty for members of the public and experts who are thinking about what might constitute maltreatment[16] as well as for children and young people who are trying to make sense of what has happened to them.[25] When delineating child maltreatment and each of its subcategories, legal documents, policy-makers and researchers draw on several key concepts, each of which are discussed below.

1.2.1 Actions, behaviour and relationships

Physical and sexual abuse tend to be defined in terms of specific types of acts against children.[3 12 13 18] Table 1-1 reports the definitions of maltreatment given in statutory guidance for England and shows actions and behaviours that are typically considered to be physically or sexually abusive.[3]

There is a broad consensus that emotional abuse and neglect should be defined and understood in terms of the nature and quality of the interaction and/or relationship between caregiver and child rather than in terms of specific acts.[3 17-19 26 27] However, definitions of emotional abuse and neglect also include some specific behaviours and it is worth noting that, unlike some other definitions of child maltreatment,[28] the definition in English statutory guidance makes specific reference to witnessing harm of others (e.g. domestic violence between parents which is classified as emotional abuse) and maternal substance misuse during pregnancy (classified as neglect; see Table 1-1). Table 1-1 also shows that English statutory guidance defines neglect as a failure to meet a child's needs. This means that the abuser must necessarily have some responsibility for meeting those needs and is most likely responsible for the upbringing of the child. Some academics argue that with the

growing importance that is placed on children's psychological needs, a clear-cut distinction between neglect and emotional abuse may seem artificial.[13 29]

Table 1-1: Definition of child maltreatment from English statutory guidance

Type	Definition
The text in this table is an abridged version of that in Working Together to safeguard Children, 2013.[6 (pp85-86)]	
Physical abuse	A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.
Sexual abuse	Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Table continued overleaf

Table 1-1: *Continued*: definition of child maltreatment from English statutory guidance

Type	Definition
Emotional abuse	The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on emotional development. It may involve conveying that a child is worthless or unloved, inadequate, or valued only in terms of another's needs. It may include denying a child opportunities to express their views, deliberately silencing them or "making fun" of what or how they communicate. It may feature age or developmentally inappropriate expectations of children, for example interactions that are beyond a child's developmental capability, overprotection, limitation of exploration and learning, or preventing the child participating in social interaction. It may involve witnessing the ill-treatment of another. It may involve serious bullying, causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.
Neglect	The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in serious impairment of the child's health or development. May occur during pregnancy due to maternal substance misuse. Neglect may involve a parent/carer failing to: provide adequate food, clothing and shelter. protect a child from physical and emotional harm or danger. ensure adequate supervision or ensure access to appropriate medical care or treatment. It may also include unresponsiveness to a child's basic emotional needs.

1.2.2 Likely harm

In a recent study which interviewed 20 members of the public, interviewees often used notions of *intent* to cause harm and *actual* harm to a child in order to "draw a line" between what was and what was not maltreatment.[16] However, law-makers, policy-makers and academics rarely rely on either of these concepts. Instead they invoke the concept of *likely* harm to a child's health or development. English legislation places an assessment of actual or "*likely* significant harm" at the centre of professional decisions about when and how to intervene in family life.[4 5] For more on significant harm and professional responses see section 1.4.1, p.41 below.

There is good reason to include concepts of *likely* harm in definitions of maltreatment. Expert paediatric psychiatrists and child development researchers argue convincingly that definitions of emotional abuse and neglect should not be predicated on *actual* harm to the child for two reasons. First, disruptions to the child's brain development following neglect and emotional abuse may not be visible.[27 30] Secondly, even if there is demonstrable harm, this can be difficult to attribute to the maltreatment.[27 30] Predicating definitions on actual harm to the child thus excludes many children who are experiencing maltreatment and who might benefit from intervention.[27] This argument is supported by the fact that there is evidence of harm in only a minority of all maltreated children, including those receiving state child protection services who are likely to be at the more severe end of the spectrum.[31] In a large UK population-based survey, 55% children who reported experiencing physical or sexual abuse reported being injured as a result of the abuse.[18] A Canadian study analysing a large sample of substantiated maltreatment investigations from 2008 suggests that rates of physical harm were higher (27%) among children investigated for *physical abuse* than for all types of maltreatment (12%).[31] The same Canadian study reported emotional or mental harm resulting from maltreatment in 31% of cases.[31] Those who challenge the inclusion of actual harm as a prerequisite for defining emotional abuse and neglect propose that these types of maltreatment should be defined in terms of the harmfulness of the parent-child interaction within the wider context of

relationships and parental risk factors, as well as the functioning of the child.[27 30] They argue that this approach allows definitions to point to appropriate ways of intervening for the child and family.[27 30]

The likely harm condition that underlies English law is present in many definitions of maltreatment, including the definition of physical and emotional abuse from the Centres for Disease Control and Prevention (CDC) in America[28] and The World Health Organisation.[32]

1.2.3 Discreet events or chronic experiences

Because of definitions relying on specific acts, physical and sexual abuse are typically conceptualised as one-off incidents *and* as incidents or experiences which are repeated over time. In contrast, many definitions of emotional abuse and neglect use chronicity as a prerequisite. This is true of the definitions given in the English statutory guidance (Table 1-1) where neglect and emotional abuse are described as "persistent". In one interview study, practitioners in England (social workers, health professionals, police and teachers) voiced concerns over using chronicity to define neglect as they felt it could delay much needed responses.[33] These professionals felt that unpredictable or inconsistent caregiving could be as harmful as persistently poor caregiving.[33] Members of the public and professionals appear to agree that all forms of maltreatment can take the form of one-off *and* chronic experiences.[16]

1.3 How big is the problem?

Child maltreatment is common in the population: a fact appreciated by both experts and members of the public.[16] Another study by the National Society for the Protection of Children (NSPCC) reported that 4% of its large representative sample of UK children aged under 18 years had experienced child abuse or neglect in the last year.[18] The definitions of maltreatment in this NSPCC study are commensurate with those given by statutory guidance for England (summarised in Table 1-1). In the same study by the NSPCC, three times as many children (11%) had experienced abuse or neglect over their lifetime. Annual incidence estimates from this NSPCC study are lower than those from other population-based studies in industrialised countries, which estimate that up to 10% of children aged under 18 years are exposed to abuse and neglect each year.[17 34]

In all these population-based surveys, rates of maltreatment are higher in adolescents than in younger children. For example, in the NSPCC study, 2.5% of children under 11 years were classified as experiencing maltreatment in the past year, compared to 6% of 11-18 year olds.[18] This may be partially explained by the design of the studies which tend to interview children aged over 11 years and *parents* of children aged under 11, leading to differential likelihood of disclosure for the two age groups. However, this is unlikely to fully explain the difference in rates. Comparison of maltreatment reports from both the child and parent in a large US study[35] and of parent-reports from 10 year olds and self-reports of 11 year olds in the NSPCC study[18] suggests that there is good comparability between the two.

There is a further bias for older children in lifetime prevalence rates. By definition, older children have had more time in which to experience maltreatment thus inflating the lifetime rates in this group compared to younger children. These population-based self-report studies consistently estimate neglect and emotional abuse (including witnessing domestic violence) to be the most common type of maltreatment and sexual abuse to be the least common.[17 18] The exception is studies relying on the Juvenile Victimisation Questionnaire as a measurement tool,

which report neglect to be less common than both emotional and physical abuse.[18] [34] [36] Despite the fact that self-report surveys of representative samples of children and parents are the best available source of data on the frequency of child maltreatment in the community, there are still problems with accuracy. Given the stigma attached to abusive behaviour and potential fear of the consequences of disclosure, results from these surveys are likely to underestimate the true frequency of maltreatment.

The problem of child maltreatment is substantial in terms of its impact as well as incidence. It is well-established that child maltreatment contributes to child mortality and morbidity and has long term impact on mental health, drug and alcohol misuse, risky sexual behaviour, obesity, and criminality.[17] [37] [38] As well as costs to the individual, there are costs to society more broadly: it has been estimated that the total costs of child abuse and neglect in America (from healthcare services, welfare services, law enforcement, legal action, education services, delinquency, crime and reduced productivity) may be as high as $94 billion dollars annually.[39] Costs are also likely to be high in England.

1.4 Professional recognition and response

Due to the magnitude, nature and impact of child maltreatment, there is a public health[8 19-21] and human rights[15] imperative to respond to the problem. This imperative to respond is reflected in English law: all professionals have a statutory duty to promote child welfare and protect children from harm.[4 5]

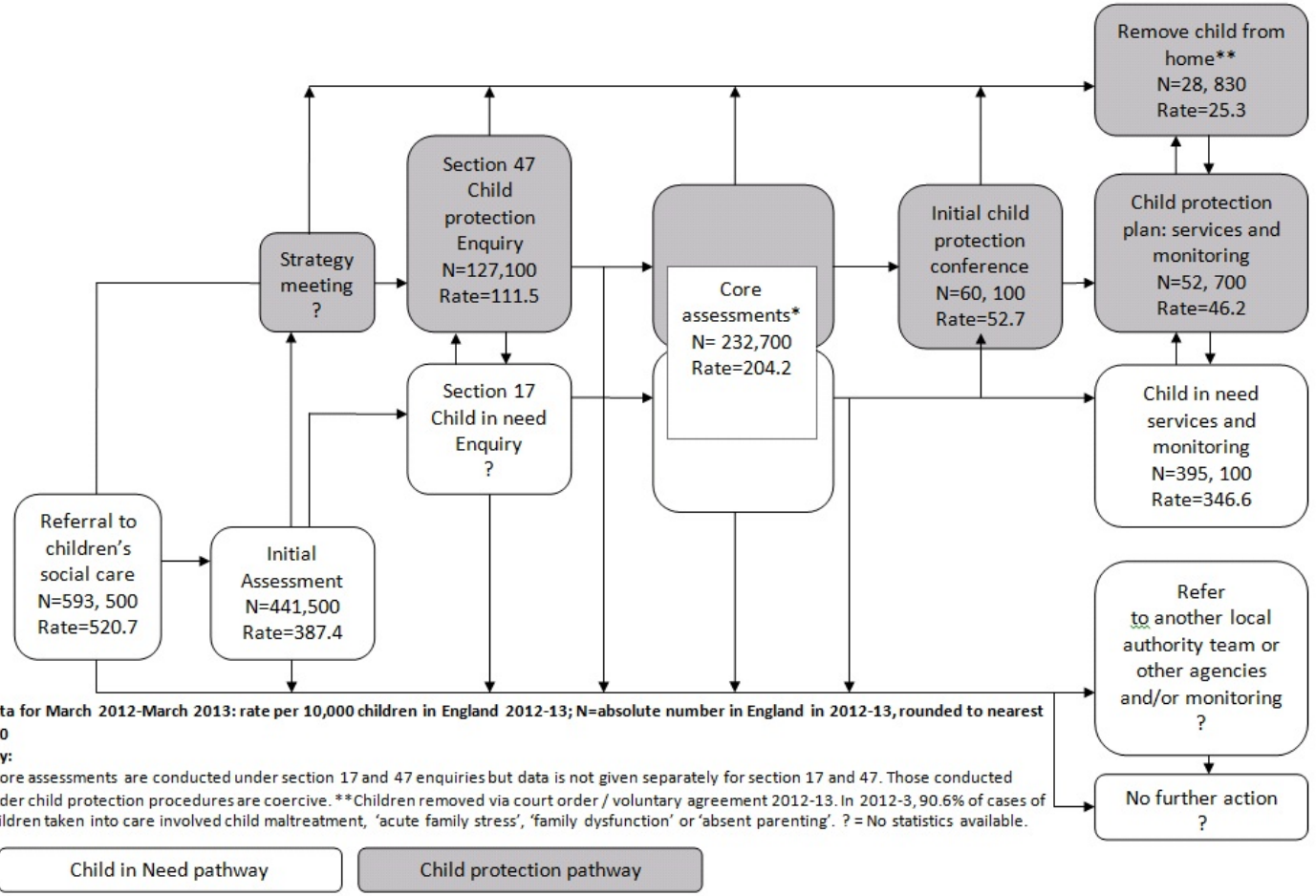
1.4.1 The role of children's social care and the child welfare system

1.4.1.1 Theory

Professional responses to child maltreatment occur in the context of the child welfare system. The problems that are recognised as child abuse and neglect and the response they elicit are heavily influenced by the way that this system functions. Since the 1989 Children Act, the English welfare system has been one of differentiated response:[4] As Figure 1-1 shows, there are two pathways to child welfare services: the child protection pathway and the child in need pathway. Professional decisions about which pathway is most appropriate for a child and family hinge on the concept of (likely) significant harm in the context of abuse or neglect. The threshold of significant harm justifies compulsory state intervention in family life according to English law in the form of the 1989 Children Act.[4] Children can move between the two pathways at any point in relation to changes in the family and professional judgments about risk and parental engagement or capacity to change.

Figure 1-1: Differential response: the child welfare system in England.

The diagram shows *incidence* data for 2012-13 (e.g.:children who were made the subject of a child protection plan during this time period). Data (rate per 10,000 children) were taken from routine government statistics.



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Significant harm is evidence by either ill treatment which is likely to (or is actually) causing harm to the child or impairment to the child and is attributable to the care given (or not given). Establishing the threshold for significant harm in individual cases depends to some extent on professional judgment. Statutory guidance for professionals states that such judgements should take into account the nature and severity of abuse, premeditation, impact on the child's health and development, parental capacity to meet the child's needs and the child's wider social environment.[6] If a child is judged to be suffering or at risk of suffering significant harm, statutory child protection procedures should be initiated under section 47 of the Children Act 1989.[4] Child protection services are delivered via a child protection plan,[3] which is a written report agreed upon by a multidisciplinary "core group" of professionals and parents/carers, led by a social worker.[6]

Child protection assessments and interventions are potentially coercive. If parents or caregivers do not comply or insufficient progress is made, legal action can be initiated to remove the child and place him or her in local authority care. For children judged to be in need of services in order to maintain a satisfactory level of health and development but not suffering from actual or likely significant harm, there is an alternative pathway to services, initiated under section 17 of the 1989 Children Act as a child "in need".[4 6] Child in need (section 17) services are voluntary: families can choose whether or not to accept state intervention. In England, a far greater number of children receive child in need services each year than child protection services (see Figure 1-1 for data).

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[3] The child protection plan is based on the core assessment of the child and family and will contain details of services that are deemed necessary, realistic goals for measurable change in parental behaviour, child and parent interaction and/or child outcome and timescales for achieving those changes. The core group, which comprises a multi-disciplinary team of parents/carers and professionals (and may include a GP), is responsible for providing or commissioning services for the child and family. There is a statutory responsibility for there to be a child protection review conference in order to reassess the child protection plan, the child and the family within three months of the initial conference and then at six month intervals (as a minimum). For more information, see HM Government. *Working together to safeguard children: an interagency guide to safeguarding and promoting the welfare of children*. London: HMSO, 2010 p.45.

The differentiated but interlinked pathways within the English child welfare system were introduced by the 1989 Children Act as part of the "refocusing debate" which continued into the mid-1990s. In the refocusing debate, it was argued that the narrow focus on child protection and establishing forensic evidence should be widened to take in the broad spectrum of child welfare, with the aim of helping families and keep policing and coercion to a minimum.[40 41] It was in this context that the 1997 Labour government introduced the term "safeguarding" into policy as a way of referring to all efforts to promote the health and development of children and to maximise their life chances.[6] This concept of safeguarding is compatible with the continuum model of child maltreatment in which maltreated children are located at one end of a spectrum. Safeguarding, as conceptualised by the then government, includes responses to need at all points of the child welfare continuum and therefore includes universal interventions (given to all children) as well as targeted child in need and child protection assessments and interventions. Under the previous government, services and systems to identify children in need grew and there was increasing responsibility placed on other non-social work professionals to help with this endeavour.[5 41 42] Although the 'Every Child Matters' policy initiative of the this government, which had safeguarding at its centre, has been shelved by the current (2010) Conservative-led coalition government,[14 43] the concept of safeguarding is still enshrined in English law via the 2004 Children Act. In England, all professionals have a statutory duty to identify children in need as well as those (at risk of) suffering significant harm and refer them to children's social care.[4 5]

In addition to the child protection and child in need pathways to services in the English child welfare system, there also exist 'early help' policies, which are aimed at children who might benefit from services but who do not meet thresholds of child in need (which includes children suffering or likely to suffer significant harm). For these children, professionals can undertake early help assessments using, for example, the Common Assessment Framework.[3] As Munro points out in her Review of Child Protection in England,[44] the phrase 'the Common Assessment Framework' is used to describe both the policy of encouraging integrated professional work to

provide early help, and the form that has been developed by Government to help professionals to conduct a holistic needs assessment. Policy-makers envisage that non-social work professionals (including healthcare professionals) undertake early help assessment with support from children's social care. In this model of early identification and intervention, the multi-agency response should occur via a multi-disciplinary Team Around the Child (or Team Around the Family) who have the role of assessing need and deciding with the child/family a course of action to provide services. In the Team Around the Child model, a non-social work professional can act as "lead professional", described in terms of an advocacy, support and service coordination role within the multi-agency response.[3] In England, there is no national strategy for provision and coordination of early help services. However, from 2014 each Local Safeguarding Children's Board (LSCB) in England must produce a threshold document to assist other professionals in responding to maltreatment and to offer guidance for them on accessing early help services.[3]

An important underlying principle of the Common Assessment Framework and the Team Around the Child model is that it is not just children's social care who are the assessors and providers of welfare services to children and families. The Team Around the Child model of early help was not intended to be used for children meeting thresholds of children in need (including significant harm or likely significant harm). Where a case involves complex needs, including significant harm, the burden of response is still placed squarely with children's social care.[3 5 41]

In theory, the concept of child safeguarding, the differentiated child welfare system and early help policies should allow professionals to access appropriately therapeutic and/or coercive services for children across the whole child welfare continuum, either via referrals to children's social care or through local routes to early help. However, there is considerable evidence that the system does not achieve these aims in practice.

1.4.1.2 Practice

1.4.1.2.1 Prioritisation of child protection responses

It is widely acknowledged that it has been difficult to sustain the political vision for a broad focus on child safeguarding in practice. As the child welfare and social work academic Jane Tunstill summarises:

> "Over decades, perennial changes have consistently skewed the balance between proactive support services for families and reactive crisis-driven child protection responses in favour of the latter."[45 (p.14)]

Public and media outcry over failure of services to prevent child deaths has been identified as a key driver of the prioritisation of child protection responses.[41] This political focus on the sharp end has been given continued impetus by the now (2010) government. This government commissioned The Munro Review of *Child Protection* in England (my emphasis)[44] and has supported the professionalization of social work.[41] In the context of a vision for child protection rather than safeguarding, it is unclear how the current government's rhetoric of early intervention and prevention of child maltreatment will translate into practice.[44 46-48] There is similar uncertainty about the concept of safeguarding. Although the term is still enshrined in English child welfare law, current statutory guidance and in the titles of key organisation structures,[4-6] the concept is in the process of being refashioned as something much narrower than was intended by the Every Child Matters policy initiative of the 2000s.

1.4.1.2.2 Scarce resources: limited supportive services for maltreated children

Just as there is no obvious theoretical cut-off between *poor* treatment and *mal*treatment for children in the middle of the welfare continuum, so there is no obvious cut-off between the allocation of child protection and child in need services for the same group of children. In practice, the labels of significant harm and child protection are used by social workers to prioritise scarce resources in an overstretched service.[49-51] In a survey of 600 social workers and managers in

England in 2013, 73% said they lacked the time, support or resources to prevent children from experiencing serious harm and 88% said that recent austerity measures had resulted in increased thresholds for statutory child protection services.[52]

This means that many maltreated children who have their problems recognised and who come into contact with children's social care will be labelled as children in need and parents and families will be offered voluntary services. Although the child in need category includes children with a wide range of welfare concerns (e.g. children and parents with a disability), the majority of children receiving child in need services are doing so due to maltreatment-related concerns (abuse or neglect 47%; "family dysfunction" 18%, "family in acute stress" 10% or "absent parenting" 3%).[53] There is a particular tendency for cases of neglect and emotional abuse to be labelled as child in need. In some cases, as the academic paediatric psychiatrist Danya Glaser argues, it may be entirely appropriate for children's social care to work with primary caregivers outside of the coercive structures of the child protection system in cases of neglect and emotional abuse.[27 54] Or it may be that longer term child in need responses are more suited to the chronic nature of neglect and emotional abuse: in March 2013 only 9% of current child protection plans had been in place for two years or more compared to 34% of children in need whose case had been open for two years or more.[53] However, in other cases, emotionally abused and neglected children are not receiving the services they need because of the way that thresholds for child protection service are used as a rationing device. In a 2012 survey of 242 social workers, 60% said they felt pressure to "downgrade" neglect and emotional abuse cases to child in need cases and 59% said that it was "quite" or "very" unlikely that children's social care would respond swiftly to children suffering neglect (72% said the same in relation to emotional abuse).[55] A 2013 survey of 600 social workers and managers suggests that thresholds are rising and particularly so for cases of neglect.[52]

Some maltreated children who do not meet child protection thresholds might be experiencing mild maltreatment or not suffering serious consequences from the

maltreatment; they might be somewhere in the grey area of the welfare continuum between *poor* treatment and *mal*treatment. The child welfare and public policy academic Jane Waldfogel describes these children as "marginally maltreated".[23] However, other children with recognised problems who are judged to be children in need will be suffering serious and sometimes fatal maltreatment. A review of 47 cases of child death or serious injury following maltreatment between 2003 and 2005 in England concluded that cases of long standing neglect rarely met child protection thresholds and, as child in need cases were subject to long waits and de-prioritisation, this could have disastrous consequences.[56]

Theoretically, maltreated children who are labelled as children in need should be receiving supportive services and multidisciplinary reviews just as frequently as children with a child protection plan.[42] However, qualitative studies of service users consistently report that families experienced a lack of services, even when requested, before child protection thresholds were met.[57-59] Studies with professionals in England tell a similar story: health visitors revealed frustration at not being able to access any services for children below the child protection threshold,[60] practitioners in universal services felt that that they had to wait for problems to "get worse" before children's social care would accept a referral[25] or that children's social care would only respond to cases of "life and limb",[61] and both practitioners and families reported a lack of services for "low level" neglect cases.[62] This experience was summed up by Dr Quirk (a GP) when providing oral evidence to the House of Commons Education Committee in 2011:

> "There does not seem to be anything underneath the children's social care child protection system that then can provide support for that family locally."[63 (p.183)]

The perceived gaps in early support services (such as parenting courses, help with family budgeting or access to early mental health support) have been attributed to lack of resources, high case-loads, welfare cuts, administrative burden and practitioners prioritising families with higher levels of need.[62] Inadequate provision of early help and preventive services has been exacerbated by the 28% cuts in Local

Authority funding: in spite of nominal support for early intervention from the Munro Review of Child Protection and backing from the current government,[44] these cuts are disproportionately affecting services designed to support children, young people and families below thresholds for child protection services.[64]

1.4.1.2.3 Child protection services: uncertainty about balance of harm and benefit

When child protection thresholds *are* reached, we do not know for sure that contact with the system provides net benefit to children and families.

There is evidence that some families experience child protection assessments and services as heavy-handed and punitive. This is in direct contrast to the stated aims of child in need *and* child protection services which were designed to be largely therapeutic and to support families to stay together. Studies based on families who had received child protection services in England[58 65] and Ireland[59] reported that a substantial minority judged the services to have caused harm, experienced assessments and reviews as "traumatic", "stressful" and "intimidating", saw child protection plans as stigmatising and as empty promises for services which were never delivered and felt as if they were living under the constant threat of having children removed. Interview studies with professionals and opinion pieces suggest that some health care professionals[66] and even social workers[67 68] share service users' misgivings about the net benefits of the child protection system, at least in some cases. The narrative about a punitive and harmful child protection system should be viewed in the context of the counter argument: based on client satisfaction surveys in the US, it has been argued that *the majority* of clients and professionals experience child protection services positively (at least as positively as other non-statutory services) and feel that social worker involvement has changed things for the better.[69 70] The low response rates of these surveys (less than 50%) raise questions about the representativeness of the sample in terms of the total population receiving child protection services and we do not know how far the results can be generalised to service users within the English system. The existing

evidence-base does not does not tell us with any certainty how parents and children in England experience child protection services on a national level.

Equally, we do not know how far child protection services improve measurable outcomes for the children and families. There is a very weak evidence-base about the balance of harms and benefits of the child protection system for children and their families, either in the UK or elsewhere.[69] Two case-series of children who had experienced significant harm[71] or reunification following out-of-home care for neglect[72 73] reported that 40-60% of children had good or satisfactory outcomes. However, in the same two studies a very substantial minority had poor outcomes with on-going and serious concerns and/or a downward trajectory. Because there is no comparator group in case series, these studies can only provide extremely weak evidence: there is no way of separating the effect of the intervention from what would have happened in the absence of the intervention.[74]

Cohort studies, which provide a comparator group, have been conducted on the effectiveness of out-of-home-care for maltreated children in terms of well-being and development in three countries (England, US and Sweden).[75-78] The studies in Sweden and the US compared out-of-home care to in-home care[78] and the study based in England[76 77] compared outcomes for maltreated children who remained in care with those who returned home. The strength of this evidence and what can be inferred is contentious. One view, as articulated by Davies and Ward is that the available data demonstrate that the majority of children who become looked after in the UK today benefit from care."[60 pp 146-7]

My view, however, is that the evidence-base is too weak to draw conclusions about whether or not out-of-home care works to improve outcomes across the population of maltreated children. Selection bias in the cohort studies prevents reliable inferences being drawn about whether out of home care is beneficial or harmful. Because cohort studies include a comparison group, they are far more informative than case series, but they cannot fully measure and account for the child and family characteristics that influence the decision to remove (or reunify) a child. These same characteristics also influence the child's outcomes, resulting in

confounding and biased results. A recent systematic review by the World Health Organization concluded that there was no clear evidence of benefit or harm of out-of-home-care for maltreated children in terms of developmental outcomes.[78]

As the equivocal nature of the evidence is driven largely by methodological weaknesses in the observational study designs (we do not know if the intervention works, rather than we are certain that it does not), researchers have called for randomised controlled trials of child protection interventions, including out-of-home care.[69 78] Ethically, randomised trials can only occur where there is genuine uncertainty about whether or not to offer the intervention to the child. [60 69 78] Results from robust randomised controlled trials are the surest way to settle the debate about the impact of child protection interventions (including out-of-home care) for maltreated children.

1.4.1.2.4 Disincentives to identify and refer maltreatment

High thresholds for service provision and ambivalence about the net benefit of referral to children's social care act as a disincentive for professionals to make children's social care referrals for any but the most obvious or serious maltreatment that they encounter. There is evidence from the USA that health professionals currently identify more maltreatment than they refer. In a prospective study, paediatricians reported that they had some suspicion of maltreatment in 10% of the injured children they had seen but reported only 6% of these children to child protection services (equivalent to children's social care in England).[79] Factors negatively affecting reporting in this and other studies included an expectation that welfare services would not be provided, a lack of confidence that reporting would improve patient outcomes and perceived harms of reporting (such as disruption of the doctor-patient relationship).[66] In England where professionals have a professional (but not legal) obligation to refer suspected maltreatment to children's social care, there are likely to be similar disincentives to refer and barriers to labelling problems as maltreatment, significant harm or child protection. Labelling the problem in this way comes with a professional obligation to refer[3] and, in the context of ambivalence about the net benefits of referring,

some practitioners may feel it best not to label or refer rather than have to do both. However, without labelling a child as suffering or at risk of suffering significant harm, it is unlikely that the family will be perceived to warrant sufficient or timely intervention in the context of overstretched and under-funded services.

A lack of confidence in available responses may also be a disincentive to *recognising* as well as labelling and referring relevant problems in children.[19 66 80] This issue is particularly acute for concerns about emotional abuse and neglect which are less likely to meet thresholds of significant harm than cases of physical and sexual abuse.[19 80] The way that available responses can affect identification of maltreatment is well explained by Brigid Daniel, the child welfare academic, writing about children that prompt concerns about neglect:

> "Many practitioners describe high levels of anxiety they feel about such [neglected] children: teachers describe sleepless nights wondering what they should do; health visitors talk of frustration in trying to make referrals to social care. There appear to be all sorts of barriers in place that prevent swift provision of help to neglected children. They include issues of role definition, confidence, hierarchies and status, procedures and bureaucracy, resources, working relationships with a family, and many more. It is likely that, for some people, the only way to reduce anxiety about such children is to cease recognising them in the first place. Not knowing how best to help can create a 'neglect filter' which enables neglect to be screened out with thoughts such as "it's not that bad really" or "they are happy underneath it" or "I've seen worse."[19 (p.16)]

1.4.1.3 Summary

In summary, despite efforts by policy-makers to conceptualise child maltreatment and relevant responses as part of a continuum of child welfare, focus and resources have been concentrated on the sharp end of the problem. There is a large group of maltreated children who do not meet thresholds of significant harm and do not seem to have access to child welfare interventions even if there has been

professional recognition of their problems and, in many cases, referral to children's social care. There are disincentives for professionals in England to label, refer and even recognise child maltreatment. Many of these disincentives stem from the limitations of responses that, despite early help policies, are perceived to depend on assessment and intervention by children's social care and to exist only for cases of "life and limb".

1.4.2 Universal services as key responders

As I have already implied, there is a large discrepancy between the numbers of children estimated to be exposed to child maltreatment each year in England (at least 4%; see section 1.3, p.39) and those who are made the subject of child protection plans each year (0.5%, see Figure 1-1).

Although annual rates of assessment and service provision by children's social care are increasing in England (between 2009 and 2013 there was an increase of 12% in initial assessments, 4% in child in need services and 19% in child protection plans),[53] these increases are small compared to the very large numbers of children with maltreatment-related problems who are not currently in receipt of welfare services. There remains a significant minority of children who are referred to children's social care and do not receive any services (almost a quarter of children referred in 2012-13).[53]

Even if the majority of the children classified as in need (3.5% of all children in England; see Figure 1-1) are receiving services for maltreatment-related problems, it is still clear that a substantial proportion of abused and neglected children is not receiving services from children's social care at any given time. Estimates from an international systematic review suggest that there may be ten times as many maltreated children in the community as receive child protection services each year.[17] Many of these children may be "marginally maltreated" but others will be at the very worst end of the spectrum. In a review of child death and serious injury in England following maltreatment in 2003-5, 83% of the families were known to children's social care at the time of the incident but only just over half were

receiving any services from children's social care and only 12% were the subject of a child protection plan.[81]

Although the 2004 Children Act broadened responsibility for child welfare beyond children's social care to other professional groups, the burden of responsibility has still been squarely placed on children's social care.[5 41] Historically, policy-makers and researchers have responded to the sub-optimal coverage of welfare services for maltreated children by focusing on increasing identification of child maltreatment by other professionals, with subsequent referral to children's social care.[19] However, it is becoming increasingly clear that an already over-stretched children's social care will not be able to offer assessment and intervention to the large numbers of maltreated children with whom they are currently not in contact. Prevention of maltreatment through early identification and intervention would involve contact with an even greater number of families. Therefore, simply increasing identification and referral of children suffering or at risk of suffering maltreatment is unlikely to improve outcomes for children and families. Instead, in the absence of extra resources, it is likely that children's social care thresholds for intervention would simply rise as a response to increased demand or that families would be monitored but not offered services.[60 82] This would create a situation where more families were exposed to the potential stress and tension of contact with children's social care without receiving any potentially therapeutic or protective services. Such was the case in a study of all children born in Western Australia in 1990 to 1991 which found that increased rates of reporting, investigation and substantiation of maltreatment by welfare services translated into higher surveillance but not an increase in supportive services.[83] The same study reported that length of service provision decreased with a higher number of open cases.[83]

As explained in section 1.4.1, p. 41 higher thresholds may actually thwart attempts to increase identification among non-social care professionals. For the reasons outlined in section 1.4.1, p. 41 high-profile academics have begun to persuasively argue that poor coverage of services for maltreated children is driven as much by

currently available responses as by sub-optimal identification of relevant problems.[19 66] Attention has turned to other professionals and their role in *responding* to concerns about child maltreatment. Academics, including those doing policy-relevant work commissioned by the Department for Education in England, have highlighted the potential of universal services in providing a *direct* response to children who prompt concerns about maltreatment.[19 44 61 66] Focussing on neglected children, Brigid Daniel states:

> "We would suggest that it is likely to be of benefit to children if universal services are able to get on and provide support for neglected children whether they are officially labelled as such or not."[19 (p.97)]

Within English healthcare services, universal services are provided by the primary care team. This is a multi-professional team consisting of GPs, practice nurses, nurse practitioners, community nurses, health visitors, midwives and other allied professionals such as physiotherapists or counsellors, though not all of these professionals will be based in the same building. The key role that health visitors can play in identifying and responding to maltreated children has long been recognised and research about safeguarding in primary care has largely focussed on this group of professionals.[19] More recently, attention has turned to the potential that the GP has for identifying and responding to maltreated children. GPs were one of only two health professionals (alongside health visitors) who were specifically referred to in Munro's Review of Child Protection in England and, as part of its Safeguarding Children Research Initiative, the previous government commissioned a study into the tensions inherent within the safeguarding role of the GP led by Hilary Tompsett and colleagues.[44 84]

1.5 Are GPs well-placed to respond to maltreatment?

Across multiple policy documents, the Royal College of General Practitioners (RCGP) has detailed the particular strengths of general practice for recognising and responding to child maltreatment. These strengths include the status of general practice as a universal and family-centred service and the longitudinal view of GPs.[85-87] In the following section, I discuss each of these potential strengths of general practice and outline the evidence that supports or challenges these claims. Before doing so, it is worth pausing here to briefly define the role of GPs and general practice in the English healthcare system.

1.5.1 Overview of general practice in England

For most people in England, general practice is the first and most commonly used point of access to the National Health Service (NHS) with nearly 300 million general practice consultations a year[88] offered by over 8000 local GP practices, also known as GP surgeries.[89 90] Like all NHS services, it is free at the point of use. In October 2013, GP practices in England had an average of approximately 7000 registered patients of all ages and approximately 1600 registered children aged less than 19 years.[90] A full-time GP sees on average approximately 100 patients a week, 15% of which will be telephone consultations and less than 5% will be home-visits.[91] On average, face-to-face consultations last just over 10 minutes each and telephone consultations about seven minutes.[91]

There are just under 40,000 fully qualified GPs in England, who are front-line generalists representing almost 40% of all qualified doctors in the country.[92] On average there are five GPs employed in each GP practice,[91] though some practices will have only one GP and some larger practices will have many more than five.

General practice forms the cornerstone of primary healthcare in England. Primary care services in England offer first-contact care delivered by a multi-professional team who offer proactive as well as reactive care to all individuals in their community, have some responsibility for population health as well as the health of

individuals and who treat ill-health in its social and cultural context.[93] Primary care services also have a gatekeeping function for access to other NHS health services.[88]

1.5.2 General practice as a universal and family-centred service

It has been argued that the status of general practice as a first-contact and family-orientated universal service offers opportunities for GPs to recognise and respond to child maltreatment.

1.5.2.1 Contact between maltreated children and GPs

Although there is no single, accurate source of data, indirect comparisons of data from different sources suggest that close to 100% of the population of England, including the child population, is registered with a GP practice.[94 95] Registered children, especially young children, present frequently to the GP: a study using a representative sample of children registered with UK general practices reported that children aged under five saw a GP an average of seven times a year in 2009.[96] This figure drops to just over two consultations per year on average for children aged between five and 18, with the exception of older teenage girls who presented twice as often.[96 97]

There is little available data on the frequency with which maltreated children present to primary care. A good quality case-control study based on low-income American children reported that children with a maltreatment report resulting in first-time foster care placement presented to paediatric primary care services about twice as often as other children in the 12 months leading up to the report.[98] This study is likely to overestimate any association between maltreatment and primary care health service use because of possible interdependence between the exposure and case ascertainment: the children who presented frequently to services might have been more likely to be identified as maltreated due to increased probability of detection and/or use of information about injuries or health care problems in the decision to place the child in foster care. This study and two American cross-sectional studies suggest that maltreated children were more likely to have incomplete and inconsistent primary care services, including a higher risk of

multiple care providers, lack of primary care provider and incomplete child immunisations.[98-100] The two cross-sectional studies have several methodological problems including very high thresholds for ascertaining maltreatment, very select samples of children who all had suspected maltreatment (i.e. not representative samples) and, in one study,[99] inadequate ascertainment of exposure (usual healthcare provider).[99 100] The results from these two studies should be treated cautiously, especially when applying them to an English setting.

Given the paucity of good quality data about how frequently maltreated children present to GPs, it is helpful to draw on indirect or supporting data. For example, we know that maltreated children are more likely to also have a physical or intellectual disability than other children, although there is insufficient evidence to ascertain whether the maltreatment or the disability came first.[101-104] We also know that rates of maltreatment are higher in lower socioeconomic groups compared to higher socioeconomic groups, although part of this trend might be attributable to ascertainment bias as studies tend to be based on children working with child protection services and poorer children are more likely to have maltreatment recognised by professionals. Higher rates of disability and poverty among maltreated children will translate to high rates of healthcare need, which despite potential barriers to service use among these groups, is likely to result in higher contact with healthcare services, including GPs. Despite the lack of good quality direct data, we might tentatively assume that maltreated children present *at least as* frequently to the GP as other children.

1.5.2.2 Contact between maltreating parents and GPs

As part of the family-centred universal care that they offer, GPs see multiple family members which can put them in a good position to identify parental risk factors for child abuse and neglect, such as depression, drug and alcohol abuse and exposure to maltreatment as a child[17] as well as domestic violence between adults in a household. A Danish study using focus groups with GPs suggests that many concerns about children in need, including those at risk of maltreatment, were prompted following recognition of parental risk factors.[105] Evidence from studies

using medical records of large and representative cohorts of UK primary care patients report that parental risk factors such as depression,[106] illicit substance[107] and alcohol dependence[108] are already recognised and clinically treated in general practice. There are opportunities for detection of domestic violence in the household; one study suggests that GPs are the most frequently sought service for the emotional and/or physical effects of domestic violence[109] and another study suggests that at least 17% of the domestic violence in presenting women was known to the GP.[110]

Despite the evidence that GPs frequently recognise and, in some cases, offer treatment for parental risk factors for child maltreatment, rates of recognition are lower than we would expect from estimates based on community samples: there appears to be room for improvement in the recognition of these risk factors.[111-113] There are no research studies in an English setting to tell us how often GPs conceptualise adult problems in terms of child safeguarding and reviews of child deaths have criticised the GPs for failing to assess the impact of e.g. maternal alcohol use on parenting capacity and the health and well-being of the child.[114] In contrast, a qualitative study of GPs in Denmark reported that most of the 70 cases of safeguarding concerns discussed by GPs in three focus groups were identified via contact with the parents.[105] Although there is little data available on how frequently GPs recognise poverty as a contributing factor to their patient's problems, GPs will certainly have opportunity to recognise this and other social problems such as poor housing, unemployment and associated stress and anxiety. Poverty and social problems are associated with frequent GP attendance in adults,[115 116] and in a Scottish study, GPs described these social factors as "co-morbidities."[117]

In summary, I found limited and indirect evidence to support the claims of policy documents that the GP position as a first-contact and family-centred universal service is utilised by GPs to recognise and respond to children who have additional social and developmental needs (children in need) or who are at risk of suffering significant harm. We can tentatively conclude that GPs in England are likely to have

regular contact with maltreated children and their families (for reasons other than the maltreatment) and that GPs are already aware of parental risk factors for maltreatment in a substantial number of their adult patients, many of whom will be parents. There is convincing evidence that recognition of these risk factors is sub-optimal and we do not know how often or when the GP considers impact of adult problems on children in the family.

1.5.3 The longitudinal nature of general practice

Traditionally GPs have had a longitudinal view of their patients, offering consistent care to the same patients over many years. This is in keeping with the chronic nature of child maltreatment which may need monitoring and intervention over long periods of time. A follow-up study of 77 children in England with a child protection plan had their case closed within a year but continued to experience significant problems over the next eight years.[71] An American study of children aged under eight years estimated that approximately 60% of children with a report to child protective services had such a report in more than one calendar year and a similar proportion had a report in more than one period of childhood development.[118] Both these studies are likely to underestimate chronicity and/or recurrence of abuse and neglect as they are based on information contained in child protection records, which is not likely to reflect events or experiences in the community.

The long-term on-going contact between GPs and their families is in contrast to the more time-limited and episodic interventions from children's social care child protection services. In 2002-13 four out of five child protection plans in England lasted less than a year and more than half were ceased within six months.[53] The short term nature of child protection services does not necessarily reflect the nature of the problem: in the same year 57% of children whose child protection plans ceased were still classified as in need by children's social care six months later.[53] The time-limited nature of services can lead to what is referred to as "revolving door" syndrome where families return repeatedly to children's social care with the same unresolved problems. Potentially, GPs can offer consistent and

on-going contact with families with chronic maltreatment who might have only episodic contact with children's social care. My literature review did not identify any research which addresses whether or how far this happens in practice.

Repeated contact over time aids long-term relationships and creates opportunity for building therapeutic relationships in general practice, which is considered a core GP skill. A "good" (therapeutic) GP-patient relationship has been described as including "friendship, respect, commitment, affirmation, recognition, responsiveness, positive regard, empathy, trust, receptivity, alignment between the doctor's agenda and that of the patient's lifeworld, honesty, reflexivity, and an ongoing focus on care that embraces prevention, illness management, and rehabilitation."[119] Relationships that have similar characteristics have been recognised as a common element of effective psycho-social interventions within social work.[120] Inevitably these relationships require time and energy to build and may pose a problem in the context of child protection work if parents are deliberately deceptive or manipulative.

1.5.4 Limitations of general practice for responding to maltreatment

In qualitative studies, practitioners and strategic level staff from health and children's social care question the GP's potential to be a key player for children suffering or at risk of suffering maltreatment. Historically, GPs have been described as uninterested in child protection and in 2005 the Royal college of General Practitioners (RCGP) admitted that child protection "traditionally enjoys the non-engagement of GPs".[85] More recently there have been survey and interview studies in English settings suggesting that other professionals place more importance on the role of GPs in child protection than do GPs themselves.[61 121] One qualitative study revealed a fear among GPs and other professionals that the average GP was not adequately skilled to handle concerns about maltreatment and that there was strong potential for GPs to over-empathise with parents with adverse consequences for the protection of children.[61] The changing nature of general practice in the UK means there is less likelihood of being seen by the same doctor at every visit. This is likely to affect continuity of care and hinder a longitudinal view,

both of which have been seen as important for the GP role in maltreatment (see Chapter 1, section 1.5, p. 56). However continuity of care and a longitudinal view might also be available in other forms, such as via the primary healthcare record.[122 123]

The same arguments for and against the centrality of the GP in responding to child maltreatment have been voiced in published debates in the British Journal of General Practice.[124-127] On one side GPs question whether GPs have time to address child maltreatment in a 10 minute consultation, whether GPs are still family-doctors who know their patients and can offer continuity of care and whether GPs see maltreatment frequently enough to give it a primary focus.[122 124] The other side of the argument states that child safeguarding, with all its difficulties, encapsulates the nature of general practice as a holistic service and is an integral part of GP work.[126 127]

1.5.5 Summary

In summary, policy-makers and some GPs see general practice as having considerable potential to play a key part in identifying and responding to child maltreatment. However, other dissenting voices raise questions about the extent to which this potential actually exists given current service configurations and whether the average GP is willing and/or skilled enough to take on this difficult role.

1.6 How *should* GPs respond to maltreatment?

1.6.1 Policy and practice recommendations

It is absolutely clear that GPs have a professional duty to identify maltreatment-related concerns, make referrals to children's social care where appropriate, share information with children's social care and other agencies and contribute to enquiries, processes and procedures initiated by children's social care. Most English policy documents focus on these aspects of the GP's role.[10] However, policy-makers are also quite clear that GPs should be doing more than simply referring concerns

about child maltreatment to children's social care and cooperating with children's social care's processes.

Guidance from the National Institute of Health and Care Excellence (NICE) in 2009 clearly acknowledges that many children who prompt concern about maltreatment by healthcare professionals will not initially or ever meet thresholds for referral to children's social care.[128] This guidance describes two levels of concern and only advises referral to children's social care when suitable thresholds of severity and certainty have been met (when maltreatment is "suspected"). The same guidance clearly indicates that action is required even when thresholds for referral to children's social care are not met (when maltreatment is "considered").

Following a concern about maltreatment, NICE recommends that GPs gather and share information with colleagues and other professionals, regularly monitor and review children and, where thresholds are met (maltreatment is "suspected"), refer families to children's social care and contribute to children's social care enquiries and interventions.[87 128] See Table 1-2 for definitions of "consider" and "suspect" and recommended actions).[128]

Table 1-2: NICE levels of concern about maltreatment and appropriate response.

<table>
<tr><th>Level of concern, as defined by NICE*</th><th>Definition</th><th colspan="2">Action required</th></tr>
<tr><td>Consider</td><td>Maltreatment is a possible explanation for a report or clinical feature or is included in the differential diagnosis.</td><td rowspan="2">Listen and observe.
Seek explanation.
Record concerns and actions.</td><td>Discuss concern with colleague
Gather collateral information
Make provision to review child.</td></tr>
<tr><td>Suspect</td><td>A serious concern about the possibility of child maltreatment but not proof of it.</td><td>Refer the child to children’s social care.</td></tr>
<tr><td colspan="4">*Described in in 2009 NICE guidance “When to suspect child maltreatment”[128]</td></tr>
</table>

As Box 1-1 shows, expectations of an on-going role for GPs from the GMC, NICE and the RCGP all relate to processes and systems for review and follow-up of children and families (with the implied aim of judging when child protection thresholds are met).

Box 1-1: Practice guidance: expectations of an on-going role for GPs for children and families who prompt maltreatment-related concerns

Appoint a lead member of staff for each vulnerable family (known to be living in "challenging circumstances") to be responsible for following-up missed appointments and any childcare or child protection concerns.[87] This good practice recommendation was reiterated in a recent review of implications for Primary Health in Serious Case Reviews by the NSPCC which stated that practices should "have in place a process and procedure for tracking and collating information on vulnerable children and families for those who do not attend appointments and who are not available for planned home visits."[129]

Follow-up concerns about domestic violence by putting in place procedures to review these families.[87]

Review progress of families where there are known parental problems, such as substance misuse.[87]

Follow-up referrals to children's social care (check if no response from social care[87] and escalate concern if you feel that the agency or professional has not responded appropriately).[130]

Make provision to review the child if there are on-going concerns which do not meet threshold for referral to children's social care[128] or following referral to children's social care (depending on level of concern).[87]

Regularly review children subject to a child protection plan at primary care team meetings.[87]

I did not find any practice guidance which contained expectations about a GPs role that went beyond referral, joint-working or review/monitoring. Although GMC guidance on child protection and recent (2014) NICE guidance on domestic violence stated that healthcare providers had a responsibility to provide on-going support or intervention to children with maltreatment-related concerns, both bodies attribute this role only to certain services, defined by NICE as "child and adolescent mental health, health visiting, sexual health, social care and specialist paediatric services for child safeguarding and looked after children and youth services".[131] The role of other healthcare services, including general practice, was conceived of as "identify and refer', either to children's social care or local early help services.

Of all the responses recommended in policy and practice documents, recording of concerns and actions has received the greatest attention. Over the last decade, there has been rising importance placed on proper documentation of concerns about child maltreatment as a necessary part of health professionals' response to the problem. In 2001, Lord Laming's report highlighted the contribution that poor record-keeping and inadequate information sharing by healthcare professionals made to the high profile death of Victoria Climbié, who had died following neglect and physical abuse three years earlier.[11] The 2006 and 2010 versions of Working Together, which were in part a response to the Laming report, provided statutory guidance to all professionals in England stating that they should record all concerns about child welfare, whether or not any action was taken, along with relevant discussions and actions.[*6 132-134] In 2009, NICE recommended that health professionals record all concerns about maltreatment whether or not the concern met the threshold for referral to children's social care (see Table 1-2).[128] In 2012 the GMC also published guidance recommending recording of relevant concerns, including "minor concerns", along with relevant clinical findings, decisions, actions,

[*]The 1991 and 1999 versions of the document made the same recommendation but did not have the status of statutory guidance, which was awarded to the guidance from the Secretary of State under section 10 of the Children Act 2004.

any information sharing with other professionals and conversations with the child or family.[130] The GMC clarified confusion about recording third party information in a patients' record by recommending that concerns about maltreatment should be recorded in both the child and parent's record, if the health professional has access to both.[130]

In short, as of 2012, there is a professional imperative for all health professionals to record all concerns about child maltreatment in the child and parent's record as part of their clinical management of the child. Recording of concerns that do and do not prompt further action is considered a fundamental and necessary response to child maltreatment by the independent regulatory body the GMC. Failure to meet these professional responsibilities may result in investigation and, potentially, removal of a doctor's right to practise medicine.

In addition to having the same responsibilities to document concerns about maltreatment as every health professional, general practice has been singled out as a setting in which there are particular opportunities for gathering and recording information and has received specific advice about recording in national policy documents. Lord Laming concluded that information gathered in general practice might be recorded and shared to help all professionals protect children from maltreatment.[11] He recommended that GP registration can be an opportunity to see the child and record wider information about the child and family, such as how well the child is cared for, living conditions and school attendance.[11] The Working Together guidance (1991, 1999, 2006, and 2010) [6 132-134] gives specific advice on recording to just two groups of health professionals. One of these recommendations is that GPs and other primary healthcare professionals should have recording systems that allow identification of children (and their siblings and parents) who are the subject of a child protection plan.[6 132-134] Since Lord Laming's 2001 report, the RCGP has published or contributed to several documents stating the importance of GPs properly recording information relevant to child protection.[85 87 135 136] Of these documents, the 2011 Safeguarding Children and Young People toolkit gives the most detailed advice, recommending the use of

specific structured codes (Read codes) in the child, parents and siblings' electronic primary care record and the uploading of child protection plans and other documents into the child and parent's record.[87]

As described above, policy documents from within and outside general practice recognise the opportunity for building up a cumulative picture of a child's social welfare via the primary care electronic health record. Specific advice for GPs includes seeking wider social welfare information at routine contacts, recording all "considered" maltreatment, even if concerns are allayed, recording concerns in the records of all family members and using specific structured Read codes to record child welfare concerns.

The potential benefits of recording maltreatment concerns are similar to the benefits of good record-keeping in general practice more generally. Good practice guidance for keeping GP records outlines the purposes of record-keeping in detail and the following paragraph is adapted from this document.[137] The primary purpose of the GP record is to aid the clinical care of individual patients by: assisting the health professional to structure their thoughts and make appropriate decisions; acting as an aide memoir during subsequent consultations; making information available to others with access to the record system who are involved in the care of the same patient (including electronic transfer of records when the patient moves practice); providing information for inclusion in other documents (e.g. case-conference reports or referrals); and storing information received from other parties or organisations (e.g. child protection plans). The records can also assist in the clinical care of the practice population by facilitating needs assessments of the population; identifying target groups; and supporting audit and improvement. The most cited benefits of recording for child protection are making children with concerns findable on the system, building up a cumulative picture where a series of minor concerns indicates a serious problem and making concerns known to colleagues, especially new or locum GPs.[87 130]

In summary, policy and practice recommendations relevant to general practice focus on the GPs role in referring to children's social care and information sharing

and joint-working with children's social care. With the exception of recording of concerns and actions, there is an absence of detail about the few other responses which are recommended by national policy, NICE, the GMC or the RCGP. There is no guidance about how the responses might work in practice, how they might best be implemented, what they hope to achieve or what resources or service context they require. The lack of detail in most recommendations raises questions about how wider responses might function in practice, what they hope to achieve, the mechanisms by which they might achieve their aims and what might hinder or facilitate these responses. The lack of clarity about how far GPs should take on a therapeutic and support role for children and families with maltreatment-related concerns is likely to hinder any further exploration of wider responses.

1.6.2 Research: which GP responses are effective, safe and feasible?

Alongside the broad-brush policy recommendations is a lack of research evidence evaluating any responses to concerns about child maltreatment in general practice in England. We simply do not know whether any recommended or other responses to concerns about maltreatment are effective, safe or feasible within current service configuration in England.

My searches located two randomised controlled trials of interventions which were indirectly relevant to the questions of effectiveness, safety and cost of GP responses to child maltreatment in England. Evaluations of the "Safe Environment for Every Kid (SEEK)" intervention in American paediatric primary care settings reported a reduction in child maltreatment in a high risk sample (measured as involvement in child protection services, medical problems relating to possible neglect and self-reported child assault by parents) and lowered psychological aggression and minor physical assaults towards children in relatively low-risk mothers.[138-140] The SEEK intervention consisted of: training doctors to recognise parental risk factors for maltreatment, using motivational interviewing techniques with families, directing families to local services and providing doctors with access to an on-site social worker. Following training, doctors felt more comfortable and confident in identifying and responding to parental risk factors for maltreatment

and doctors who received the training were viewed favourably by patients.[141] There were methodological limitations to this trial including high loss to follow-up (20%) and lack of an intention-to-treat analysis. Even if we agree that the results of the trial are promising, this intervention was implemented with *paediatricians* in a primary health and welfare system that is significantly different to the English model. For example, doctors in American paediatric primary care settings have a responsibility only for the children of a family whereas commonly parents and children share the same GP in an English primary care setting. We do not know whether or how far the results can be generalised to an English general practice setting.

Evaluations of interventions to improve outcomes for women experiencing domestic violence provide the second set of indirect evidence about GPs' responses to concerns about child maltreatment in England. The "Identification and referral to improve safety (IRIS)" trial evaluated a training plus support intervention for women experiencing domestic violence in general practice in two Primary Care Trusts (PCTs) in England. The intervention programme included practice-based training sessions, a prompt within the medical record to ask about domestic abuse, and a referral pathway to a named domestic violence advocate, who also delivered the training and further consultancy. The IRIS trial used referrals as its main outcome measure and reported a much increased referral rate in the intervention practices to the specialist advocacy service (incidence rate ratio: 22.1 (95%CI 11.5, 42.5)) and two other specialist domestic violence agencies (incidence rate ratio: 6.4 (95%CI 4.2, 10.0)).[142]However, in absolute terms, the increase in referrals was so small that it was unlikely to be of any clinical significance (increased from 0.03% to 0.04% of all women) and other researchers question whether an increase in referrals indicates an improvement in services and/or outcomes for women.[143] The cost effectiveness analysis of the trial was very uncertain: the confidence intervals (CI) indicate that there could be a societal cost of as much as £136 per woman or a societal saving of up to £178 per woman over one year.[144] There is no mention of children or child safeguarding in any of the publications relating to the IRIS study. A similar trial in Australia ("Women's evaluation of abuse and violence care in general

practice" (WEAVE)) evaluated training of GPs to identify domestic violence and offer/deliver several 30 minute counselling sessions on emotions and relationships to women with identified domestic violence. This trial did not find any difference between the intervention and control groups in quality of life, safety planning and behaviour, or mental health 12 months after the intervention. GP inquiry about the safety of children was higher in the intervention group at six months post-intervention (odds ratio: 5.1 (95%CI 1.9, 14.0)) but we do not know whether this had any impact on women or their children.[145 146]

1.6.3 Summary

In summary, policy documents recommend that GPs record concerns, share information, discuss with colleagues and follow-up and monitor families who prompt concerns as well as make referrals to children's social care when thresholds are met. GPs might also take on a "lead professional" role for children below the threshold for children's social care child protection procedures, including advocacy and support for parents and coordinating services. These policy recommendations lack detail: there is little in the way of theory about how these responses might be expected to improve outcomes for families, little detail about how responses might work in practice or what service contexts and resources are needed. There is an absence of research data for policy-makers to draw on to develop their recommendations. My literature review did not find any research evaluating the effectiveness, safety or cost of any responses by GPs to concerns about maltreatment in an English primary care setting. Indirect evidence from trials in other countries and/or about GP responses to domestic violence is inconclusive. It is not at all clear if strategies such as on-site social workers/access to specialist staff or motivational interviewing/counselling of parents with risk factors for maltreatment are likely to improve outcomes for children and families. Since conducting my literature review, the US Preventive Services Task Force has published the results of a systematic review of primary care interventions to prevent child maltreatment in children with relevant risk factors.[147] The task force found only one trial of an intervention that could be implemented in a clinical

primary care setting: the SEEK study described above. Like me, the task force concluded that there was insufficient evidence to assess the balance of benefits and harms of interventions delivered in primary care to prevent child maltreatment.

With broad-brush policy recommendations and lack of research evidence, it is very difficult to provide a full description of what GPs *should* be doing in response to concerns about child maltreatment.

1.7 How *could* GPs respond to maltreatment?

Without a detailed evidence-based specification for what GPs *should* be doing, exemplars of current or good practice can at least tell us about *possible* GP responses to concerns about child maltreatment. To my knowledge, there is only one existing source of empirical data describing strategies that GPs could use to respond to concerns about child maltreatment in an English setting.[61] The study by Tompsett and colleagues consisted of: a literature review; a survey of 96 English GPs, in-depth interviews with GPs (N=14); interviews with key stakeholders (N=19 including strategic level staff from two PCTs and Local Safeguarding Children's Boards (LSCBs)); three focus groups with young people, young mothers and a minority ethnic group; and a Delphi consensus about the guiding principles of GPs in safeguarding children (with 25 experts). Data were collected between 2006 and 2007. The study identified four (not mutually exclusive) roles that GPs could adopt in responding to maltreated children:

1. **The case holder:**

   GP has on-going relationship with family before, during and after referral to children's social care. This role builds on voluntary disclosure and establishing trust over time with the parents. This role was clearly identified by GPs but not recognised so much by the stakeholders.

2. **The sentinel:**

   GP identifies child maltreatment and refers the concern to children's social care or other health services.

3. **The gatekeeper:**

   GP provides information to other agencies so that those agencies can make decisions about access to services.

4. **Multi-agency team player:**

   GP has continued engagement with other professionals outside the practice. This role is fulfilled when GP contributes actively to children's social care child protection processes.

The exemplars of good practice following safeguarding concerns included involving parents in safeguarding decisions and taking time to make those decisions, being clear with parents about limits of confidentiality, encouraging consultative and reflective practice, sharing information with other professionals, arranging for follow-up of a child when there were on-going concerns, ensuring that parent and child had a separate GP where there were conflicts of interest, recording concerns and taking a long-term view. Many of these good practice recommendations overlap with policy recommendations (see 1.6 above) and the study does not provide detail or context for implementation of these recommendations.

1.8 How *do* GPs respond to maltreatment?

The little evidence we have about what GPs do in response to maltreatment-related concerns focuses on their participation in children's social care processes and (to a lesser extent) participating in multi-disciplinary teams to help children access early help. The little research that exists suggests that GPs frequently do neither. A study using 200 consecutive case conferences that took place in 2000 reported that only 11% of invited GPs attended the conference and a similar proportion submitted a written report.[148] Although GPs have commonly cited lack of notice as a reason for not attending,[149] the study did not find any difference in attendance rates when stratified by length of notice given to the GP by children's social care (See Figure 1-1 for diagram of case conferences in relation to the overall child protection system).[148] Similarly, qualitative studies report that (in the eyes of both GPs and other professionals) GPs are disengaged from local systems for early identification

and prevention of social welfare problems in children.[62] In his evidence given to the House of Common Select Committee Dr Quirk (a GP) commented that "the majority of GPs in England would not know what the CAF [Common Assessment Framework] stood for and do not use it."[63]

We know little else about what GPs are currently doing in response to concerns about child maltreatment. We do not know how often GPs in England "consider" or "suspect" child maltreatment, how often they refer children to children's social care for this reason or what other actions they may take. Routine data on referrals to children's social care in England are not published with details of referral source[53] and there is an absence of any other data to answer this question.

Despite the policy focus on recording of concerns, we do not know how often, how or why GPs record concerns about maltreatment. Reports from a workshop and the mixed methods study by Tompsett and colleagues suggest that there are barriers to recording: GPs worries about the ethics of documenting concerns, especially in third party records, and the potential consequences of a permanent record, which might be seen by other professionals or family members.[61 150]

1.9 Summary of rationale

In England, children's social care is unable to adequately respond to the large numbers of children who are experiencing or at risk of experiencing child maltreatment. There is widespread acknowledgement among policy-makers and academics that referral to children's social care cannot be the only possible response for other professionals when they have concerns about child maltreatment: a range of responses is required.

Policy-makers and academics propose that universal services are well placed to take on responses to maltreatment, including *directly* responding to children and families who prompt concerns about child maltreatment. Policy-makers and some GPs repeatedly state that GPs have considerable potential to fulfil this role but in qualitative studies, other GPs and stakeholders challenge how far this potential actual exists. Limited and indirect evidence suggests that GPs *may* be well placed to respond to maltreatment.

Potential responses to maltreatment-related concerns in general practice have not been fully defined and, with the exception of recording concerns, recommendations remain broad-brushed and lacking detail. We do not know how these recommendations might best be put into practice or what skills, resources or service contexts are needed. Nor do we know if these or any other responses are effective, safe or feasible in terms of resources.

Before researchers can begin to address questions of implementation and evaluate the effectiveness, safety and cost of any response, there must first be a detailed description of the responses in question. To-date, there is very little empirical data about good or current practice that can help us build a detailed description of possible responses to concerns about maltreatment by GPs.

In this context of broad-brush policy recommendations, lack of empirical studies and continuing contention about the GP role among GPs in England, there is a pressing need for empirical research describing current and/or best practice for GPs when responding to concerns about child maltreatment in England. As the child

welfare academic June Thoburn also argues, this research should work towards understanding which components of “service as usual” might be effective practice.[151] This thesis aims to address this need for an improved evidence-base relating to the role of GPs in responding to maltreatment-related concerns.

1.10 Scope of thesis and definition of terms

1.10.1 'Maltreatment-related concerns'

The scope of this thesis includes all forms of abuse or neglect (maltreatment) in children and unborn babies aged less than 18 years. In keeping with the major burden of maltreatment and because of the family-focus of general practice, my emphasis is on abuse and neglect involving a parent or primary caregiver. The term parent will be used to refer to the biological parent, an adoptive or de facto parent or the partner of anyone in a parental role.

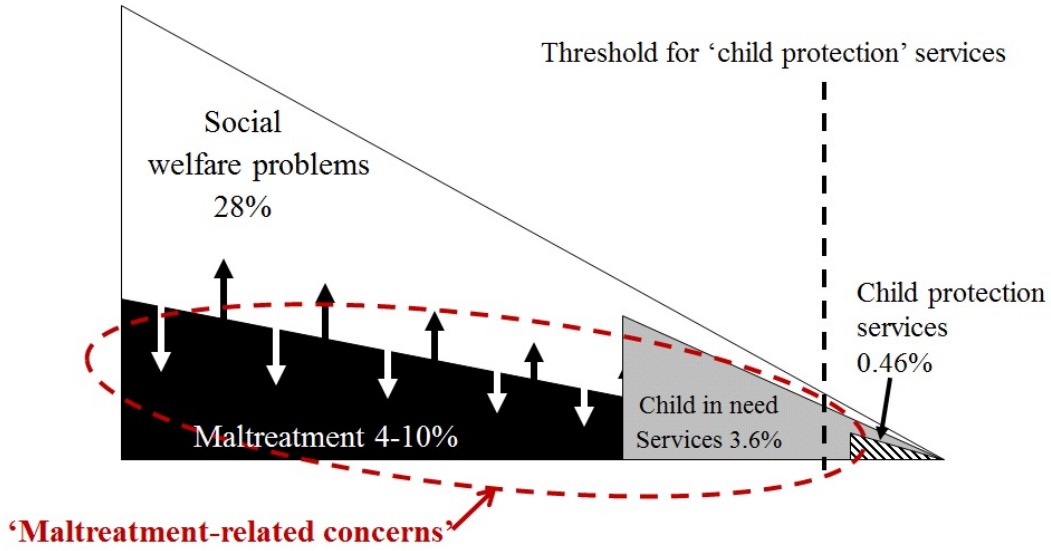
As described in section 1.2, p. 32 it can be hard for professionals to know where to draw the line between poor parenting and abusive parenting. The way that problems are labelled is driven by the functioning of the welfare system and professional perceptions of this system as well as perceived parental cooperation and capacity to change. Maltreated children whose problems are identified by professionals are not necessarily labelled as a child protection cases or described as suffering actual or likely significant harm. My aim is to investigate responses to all forms of abuse and neglect in children. This includes children who are perceived to be "marginally maltreated" or are suffering risk factors for maltreatment as well as those at the severe end whose abuse or neglect is obvious, certain and severe. In theory, children in the middle as well as at the sharp end of the spectrum would benefit from intervention. Consequently, the scope of this thesis includes any professional concern about possible, future or actual maltreatment regardless of how the concerns are officially labelled or whether the child is judged to meet thresholds for statutory child protection enquiries or interventions at that time. In this thesis, I use the term "maltreatment-related concern" to capture this full range of professional concern about child maltreatment.

In some cases, a maltreatment-related concern may be a professional worry that a parental problem, such as depression or alcohol misuse, is affecting the emotional development, social skills and speech of a child, with potential for worsening or increased impact over time. The professional may judge that the compromised

parenting *does not currently* warrant being labelled as “maltreatment” or the impact as “significant harm”. Nonetheless the professional concern is that the problem *will* or *could become* maltreatment. Alternatively, a maltreatment-related concern could be a suspicion about a non-accidental injury, including those in which suspicion dissipates after further investigation. Or a professional may be very clear that a child is at risk of “significant harm” but due to parental compliance or assessments by other professionals, the family may be receiving voluntary child in need services (or no services) rather than child protection services. Finally, “maltreatment-related concerns” includes concerns that are absolutely and definitively about child maltreatment and are labelled as such, for example concerns about the safety of new babies where older siblings have been removed from home due to abuse or neglect.

Figure 1-2 shows how maltreatment-related concerns can pertain to children experiencing maltreatment or children exposed to parental problems (e.g. drug misuse) which are risk factors for maltreatment and can include children receiving services from children’s social care (child in need or child protection) as well as those who are not in contact with children’s social care.

Figure 1-2: 'Maltreatment-related concerns': scope of PhD study.



Social welfare problems: 28% of the total child population in England is experiencing two or more hardships at any given time (e.g. parental depression or alcohol or substance misuse, financial stress or overcrowding), based on 12,583 children and parent dyads from the UK birth cohort study the "Millennium Cohort Study").[152] 2% of families experience five or more indications of disadvantage (no parent in the family is in work, family lives in poor quality or overcrowded housing, no parent has any qualifications; mother has mental health problems; at least one parent has a longstanding limiting illness, disability or infirmity; family has low income (below 60% of the median); or family cannot afford a number of food and clothing items), based on a cross-sectional survey of a representative sample of 7,657 families in 2005.[153] Although it would be preferable to report data stratified by potential risk factors for maltreatment (e.g. parental drug misuse or depression) and problems relating to family environment (e.g. housing or unemployment), neither of the studies cited above presents data in a way that allows this.

Maltreatment: at least 4% (and as many as 10%) of children experience abuse or neglect each year in developed countries, based on self-report studies of children and parents.[7 8 17 18 34]

Child protection services: 0.46% of children in England were made the subject of a child protection plan in 2012-13.[53]

Child in need services: 3.6% of children in England were offered 'children in need' services in 2012-13.[53]

1.10.2 'Response'

Given the limitations of referral to children's social care as the only response to maltreatment-related concerns, I am particularly interested in wider responses that may happen alongside or instead of referral to children's social care. These might be ones that are clearly recognised as part of a safeguarding role, as responses within established early help systems or ones that have not yet been explored in policy or research.

Given the slippery definitions of safeguarding and the reality of scarce resources for children below the child protection threshold, it is unsurprising that professionals use the terms child safeguarding and child protection interchangeably to refer to professional activity to protect children from abuse and neglect.[61 154] This thesis is interested in professional responses to maltreatment-related concerns regardless of whether professionals term these responses child safeguarding or child protection (or neither).

In this thesis, I use the term "child protection" to refer to statutory child protection procedures for children who are judged to be suffering or likely to suffer significant harm, including attempts to initiate child protection procedures such as a child protection referral. I shall use the term "safeguarding" to refer to all professional responses to maltreatment-related concerns, including those beyond formal or statutory child protection procedures. Although I use the term safeguarding, my focus is on responses to abuse and neglect rather than wider child welfare problems, such as disability or bullying from peers, which can occur in the absence of maltreatment.

1.11 Key points from Chapter 1

- Despite overt policy aims to the contrary, there is a persistent sub-text in policy which portrays the role of the GP as primarily to "identify and refer", either to children's social care (for children meeting "child in need" thresholds) or to community support services (for children requiring "early help"). Limiting the GPs role to the "identify and refer" role is problematic in the context of insufficient early help services to which to refer and ambivalence about the net benefits of referring to children's social care.

- GPs may be well-placed to enact responses to children and families that can co-exist with and also continue beyond the threshold-driven and time-limited services provided by children's social care. Such responses may exist within local systems for early help, with which GP engagement is thought to be poor. It might also include other responses which have not been defined or described (let alone evaluated for benefit, harm and cost).

- This thesis aims to contribute to the evidence-base which can be used to develop GP responses to child maltreatment.

- The scope of this thesis covers all concerns about maltreatment, including those:
    - about parental risk factors for maltreatment (e.g. drug misuse).
    - which dissipate after further investigation.
    - are about children not currently involved with children's social care and/or not meeting thresholds for intervention by children's social care.

  I use the term "maltreatment-related concern" to describe this full spectrum of professional concern about maltreatment.

2 CHAPTER 2: Aims, objectives and structure

Statement of authorship

The literature review of mixed methods research which is presented in this chapter was carried out collaboratively by myself and another PhD student. We each reviewed the literature independently and using our own approach. We then met several times to discuss our findings and structure our thoughts. This literature review resulted in a published paper giving an overview of mixed methods in health research (reproduced in Appendix 9.2).[155] The application of theory to the design of my PhD study was completed independently.

2.1 Content and structure of Chapter 2

In this chapter I describe the overall aim of the study and describe the aims and objectives for each of the four study phases. Additionally, I present the study design and the rationale for using mixed methods. Finally, I explain the structure of this thesis.

2.2 Overall aim

To describe and understand responses to maltreatment-related concerns by GPs in England.

2.3 Study phases: overview

There were four phases to this PhD study.

Phase 1 Development phase: essential ground work for phases 2 and 3 via collaboration with the RCGP and 11 GP practices in England.

Phase 2 Quantitative study phase: analysis of recording of maltreatment-related concerns in a large representative sample of English GP practices.

Phase 3 Qualitative study phase: in-depth exploration of wider GP responses to maltreatment-related concerns in a small sample of English GPs, health visitors and practice nurses.

Phase 4 Mixed methods phase: integration of findings from quantitative and qualitative data (i.e. mixing of methods) in order to draw conclusions about GP responses to maltreatment-related concerns in England.

Each of the four phases had its own aims and objectives in relation to understanding GP responses to maltreatment-related concerns

2.4 Aims and objectives for each phase

2.4.1 Phase 1: development phase

2.4.1.1 Aim

To understand recording of maltreatment-related concerns in general practice and familiarise myself with GP culture and practice in relation to child safeguarding. This was essential preparatory work to facilitate Phases 2 and 3, and was undertaken in collaboration with the RCGP and 11 'expert' practitioners from 11 GP practices in England.

2.4.1.2 Objectives

2.4.1.2.1 Development for Phase 2

1) To understand how and why GPs record concerns about child maltreatment.
2) To develop a Read code list to measure maltreatment-related concerns in children's primary healthcare records.
3) To understand this measure of *recorded* maltreatment-related concerns in terms of sensitivity and specificity for *known* maltreatment-related problems.
4) To estimate the frequency of maltreatment-related concerns in 11 practices.
5) To develop a consensus among the 11 GPs about the best approach to record concerns.

2.4.1.2.2 Development for Phase 3

6) To gain a better understanding of whether the design of the qualitative study (Phase 4) was feasible and likely to generate rich data.
7) To identify sites for qualitative data collection, understand GP culture and build gatekeeper relationships to facilitate access.

2.4.2 Phase 2: quantitative study

2.4.2.1 Aim

To quantify maltreatment-related concerns recorded by GPs.

2.4.2.2 Objectives

1. To estimate the frequency and type of maltreatment-related concerns recorded in children's electronic health records using a representative population sample, overall and by child characteristic.
2. To estimate variation of recorded maltreatment-related concerns by over time and by practice in the same representative sample.

2.4.3 Phase 3: qualitative study

2.4.3.1 Aim

To describe and understand GP responses to concerns about child maltreatment.

2.4.3.2 Objectives

1. To generate hypotheses about what constitutes a maltreatment-related concern for a small sample of GPs.
2. To generate a rich description of the types of responses that a small sample of GPs use in responding to maltreatment-related concerns.

2.4.4 Phase 4: integration of findings

2.4.4.1 Aim

To draw conclusions about GP responses to maltreatment-related concerns and to suggest next steps for research, policy and practice.

2.4.4.2 Objective

1. To integrate findings from quantitative phase (Phase 2) and qualitative phase (Phase 3) in order to broaden and deepen understanding about GP responses to maltreatment-related concerns in England.

2.5 Mixed methods research: my PhD study design

The following sections describe and justify my mixed methods research design, drawing on a literature review of mixed methods theory. I used a snowballing technique for the literature review,[156] which involved two stages. First, I located relevant publications via Google, Google Scholar, colleague recommendations and hand-searches of the Journal of Mixed Methods Research (http://mmr.sagepub.com/). Secondly, I used these relevant publications to identify other relevant texts via bibliographies and via the "cited by" links on Google Scholar and the Journal of Mixed Methods Research website. I undertook this literature review between October 2009 and December 2011.

2.5.1 What is mixed methods research?

The most widely accepted definition of mixed methods research is research "collecting, analysing, and mixing both quantitative and qualitative data in a single study or a series of studies".[157] In my PhD study, the quantitative data came from structured information recorded in routine health records in a sample of 11 GP practices and a large UK database of over 400 GP practices. The qualitative data came from workshops and interviews with GPs from these same 11 practices and observations of their team meetings. Central to the definition of mixed methods research is the *integration* of quantitative and qualitative data at the design, analysis and/or interpretation stage.[157 158] See page 94 below for more details about the planned integration of different data types in this PhD study.

2.5.2 Why did I use a mixed methods design?

In this PhD study, I set out to examine different aspects of one complex topic and each of the questions I asked demanded a different methodology. Estimating *how frequently* GPs recorded maltreatment-related concerns was best done using epidemiological methods and a large representative dataset in order to maximise precision and generalizability of results. Gaining an understanding of how and why GPs responded to maltreatment-related concerns, including insights into GP recording practices, could only be answered by in-depth qualitative work with GPs.

Qualitative methodologies are needed to understand how or why things are happening or for explaining complex social or cultural phenomenon.[159] Using mixed methods in this way, with the aim of extending the breadth and range of enquiry (promoting "comprehensiveness")[160] by using different methods for different enquiry components, has been termed "expansion" by mixed methods theorists.[158] [161] [162] As described in Table 2-1, when describing the expansion approach to mixed methods research, researchers have compared the individual quantitative and qualitative components to pieces of a jigsaw or as islands and have described their mixed methods design as illuminating more of the picture or landmass. From this perspective, each method is seen as having additive benefit and allowing breadth of understanding about a topic or problem.[160]

Table 2-1: Rationale and justification for different mixed method study designs.

Rationale of mixed methods design	Potential benefits
Expansion Setting out to examine different aspects of a research question (different phenomenon), where each aspect warrants different methods.[158 162-164]	Researchers have compared methods in this approach to pieces of a jigsaw or islands and have described their mixed methods design as illuminating more of the picture or landmass. Methods seen as having additive benefit and allowing breadth of understanding.[160]
Complementarity Using different methods to access various dimensions of the same phenomenon.[158 159 162 165 164]	Methods seen as multiplicative and allowing depth of insight about a topic or problem.[160]
Development Using results from one method to develop or inform the use of the other method. Also known as "facilitation".[159 165]	Allows improved study components e.g. survey designed following qualitative fieldwork.[160] Qualitative research is often seen as the logical precursor of a quantitative study component.[159]
Triangulation Comparing findings to interpret phenomenon, including validation (using one method to confirm the findings of another) and initiation (using results from different methods specifically to look for areas of incongruence in order to generate new insights). Also known as "clarification".[164-166]	Permits more confidence in results.[160]
Emancipation Using qualitative research alongside quantitative to give marginalised groups a voice.[160]	Fulfils political agenda.[160]
Salvaging Using one method to save another that has floundered.[160]	Salvaging an otherwise failed study or understanding why one study component failed. [160]

A secondary rationale of my mixed methods design was to seek depth as well as breadth in my findings by using different methods to illuminate the same phenomenon (known as "complementarity"). I anticipated that this would only be possible for recording of concerns about child maltreatment, where the quantitative and qualitative data could obviously overlap in topic.

Although analyses of published mixed methods studies in the field of health research identify "expansion" as the most commonly cited reason for using a mixed methods design,[167] researchers also use other important rationales, including "complementarity" (see Table 2-1 for a list and explanation). As Table 2-1 shows, underlying all rationales is the claim that a mixed methods approach can answer some questions better than using either quantitative or qualitative methods alone.[157]

Mixed methods research can be especially powerful when addressing particularly complex issues. These might include health services interventions[168] and living with chronic conditions.[169] There are several aspects of responding to child maltreatment that place it in the arena of a complex problem and make it fertile ground for mixed methods research: its hidden nature; the influence of moving service thresholds on recognition and/or labelling of maltreatment; the social stigma attached to the label; the considerable harms of failing to recognise child maltreatment both for the child and for the professional alongside the potential harm of the child protection system for families; the practical constraints of general practice as a service; and the need for interagency working between professionals.

2.5.3 My theoretical stance: pragmatism

Some researchers argue that it is not possible (or desirable) to combine qualitative and quantitative methods as they are much more than methodologies and, instead, represent essentially different and conflicting ways of viewing the world and how we collect information about it.[170] Quantitative research is associated with a positivist theoretical stance and a belief that reality can be measured and observed objectively. It sets out to test an a priori hypothesis and is therefore conventionally described as using a deductive approach. On the other hand, qualitative research comes from an interpretive framework and a belief that there are multiple realities shaped by personal viewpoints, context and meaning. Qualitative research aims to provide a rich description of views, beliefs and meaning and acknowledges the researcher's role in shaping and co-producing the data. It is described as inductive as it is open-ended and allows hypotheses to emerge from data. The difference has been summarised as "looking for answers [positivist] versus looking for questions [interpretive]."[171]

Some researchers argue that mixed method research should attempt to disengage itself from specific paradigms,[158] while others argue that its own philosophical assumptions make mixed methods research a "third paradigm".[157] In my mixed methods research I have deprioritised debates about research paradigms. I take a pragmatic view and advocate judging a method by how well it can answer the specific research question. This pragmatic view tends to be associated with *applied* health services or policy research, such as that which I am conducting for my PhD, and is also known as a "horses for courses" or "toolkit" approach.[170]

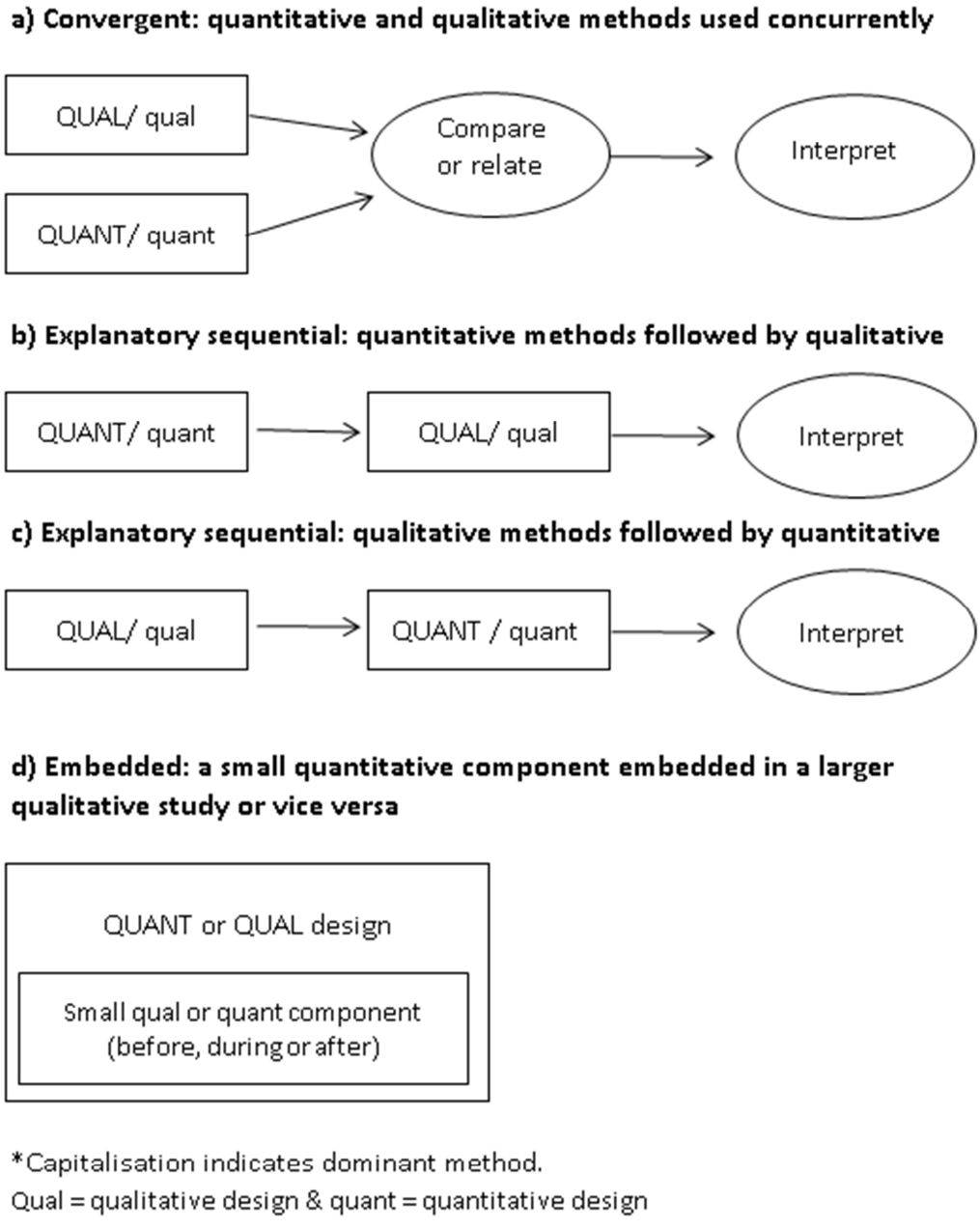
2.5.4 The mixed method design

Like all researchers, the way I designed my study was influenced by practical considerations as well as theory. I chose a convergent mixed methods design (see Figure 2-1) in which the qualitative and quantitative components were undertaken simultaneously. Conducting the qualitative and quantitative components concurrently allowed me to analyse the quantitative data in the down-time phases

of the qualitative study (e.g. waiting for ethical approval and waiting to hear back from potential participants). I took this approach to maximise efficiency within a time-limited project. I gave equal weight to the qualitative and quantitative elements in terms of resources (time and energy) for two reasons. First, the two research questions had equal importance in terms of policy relevance. Secondly, I wished to be equally trained in both methodologies rather than specialising predominantly in one. As Figure 2-1 illustrates, the mixing of the quantitative and qualitative data takes place at the analysis and interpretation stage of a convergent mixed methods design. This suited my study for the following reasons. First, the practical necessity of both studies running concurrently limited opportunity for one set of sub-study results to influence the design of the other sub-study (this would have been an “explanatory sequential” or an “embedded” design, see Figure 2-1). Secondly, the sub-research questions within my PhD study were largely independent and I anticipated most insights by contrasting and comparing the results.

Figure 2-1: Classification of mixed methods designs.

This classification is based on that from Creswell and Clark, 2007[157]



*Capitalisation indicates dominant method.
Qual = qualitative design & quant = quantitative design

2.5.5 Integrating the two data types

In keeping with the convergent mixed methods design, the quantitative and qualitative data in my PhD study were largely kept analytically distinct until the interpretation phase (see Figure 2-1).[172] I used established statistical techniques for analysing the quantitative data (described in Chapter 4, section 4.5.7, p. 146) and robust thematic analysis for the interview data (described in Chapter 5, 5.4.9, p. 187) and linked the results from the sub-studies at the interpretation stage, when the results from both analyses were compared, contrasted and combined. There are two approaches to mixing data at the interpretation stage. First, inferences can be drawn from sub-studies and then these inferences combined to make "meta-inference" or, secondly, the findings from each method can be brought together in the discussion as inferences. [160 173] To maximise the usefulness of the sub-studies, including publication of the sub-studies, I chose the former method (combining inferences).

When studies aim for "expansion" using a convergent design and analytically distinct sub-studies, there is a particular risk that there will be insufficient integration of the data from the sub-studies and opportunities to improve understanding will be lost.[160] To encourage integration of the results from the sub-studies I made conscious efforts to question how the data sources worked together and dedicated Chapter 7 to mixed methods results.

2.5.6 Potential challenges in my mixed methods design

Despite its considerable strengths as an approach, mixed methods research can present researchers with practical as well as theoretical challenges.[161 174] First, combining two methods in one study can be time consuming and requires experience and skills in both quantitative and qualitative methods. There is a risk that mixed methods researchers have only a superficial grasp of both methods. By collaborating with epidemiologists, statisticians and qualitative researchers, I hoped to achieve a credible level of skill in each method. A second challenge is the achievement of a true integration of the different types of data as it requires

innovative thinking to move between different types of data and make meaningful links between them. It is therefore important to reflect on the results of a study and ask if your understanding has been enriched by the combination of different types of data. This was the question I asked myself during the interpretation and conclusions phase (Phase 4) to steer a path towards useful integration.[161]

Finally, there are difficulties in presenting mixed methods research.[161] Researchers may decide to present their quantitative and qualitative data separately for different audiences. Many journals in the medical sciences have a distinct methodological base and relatively restrictive word limits which may preclude the publication of complex, mixed methods studies. However, as the number of mixed methods studies increases in the health research literature[167] this may change. I have myself encountered these difficulties. I have chosen to present the results of the quantitative and qualitative sub-studies separately in this thesis and to draw them together in Chapter 7 (Phase 4). My plan for publication followed the same strategy.

2.5.7 Summary of mixed methods design used in this PhD study

In summary, the mixed methods design of this study primarily aims for expansion: achieving breadth of understanding by examining different aspects of the topic with different methods. Where possible, I also sought complementarity: achieving depth of understanding by using different methods to examine the same aspect of the topic. My design reflects a pragmatic view of mixing methods in which quantitative and qualitative methods are used together despite inherent and potentially unresolvable conflicts in their underlying paradigms. As Figure 2-2 shows, my mixed methods design was a convergent one where the quantitative and qualitative sub-studies took place simultaneously, the two components were given equal weight and analysis of the two sub-studies were separate until the interpretation and conclusions stage (Phase 4; Chapter 7).

2.6 Structure of this thesis

This thesis is divided into eight chapters. Figure 2-2 provides a visual representation of the structure of the study and of this thesis. The chapters report the following components of the study:

Chapter 1: Introduction and rationale

Chapter 2: Aims, objectives and structure (including mixed methods design)

Chapter 3: Development phase of study

Chapter 4: Methods and results from epidemiological analysis of THIN database

Chapter 5: Methods for qualitative interviews and observations

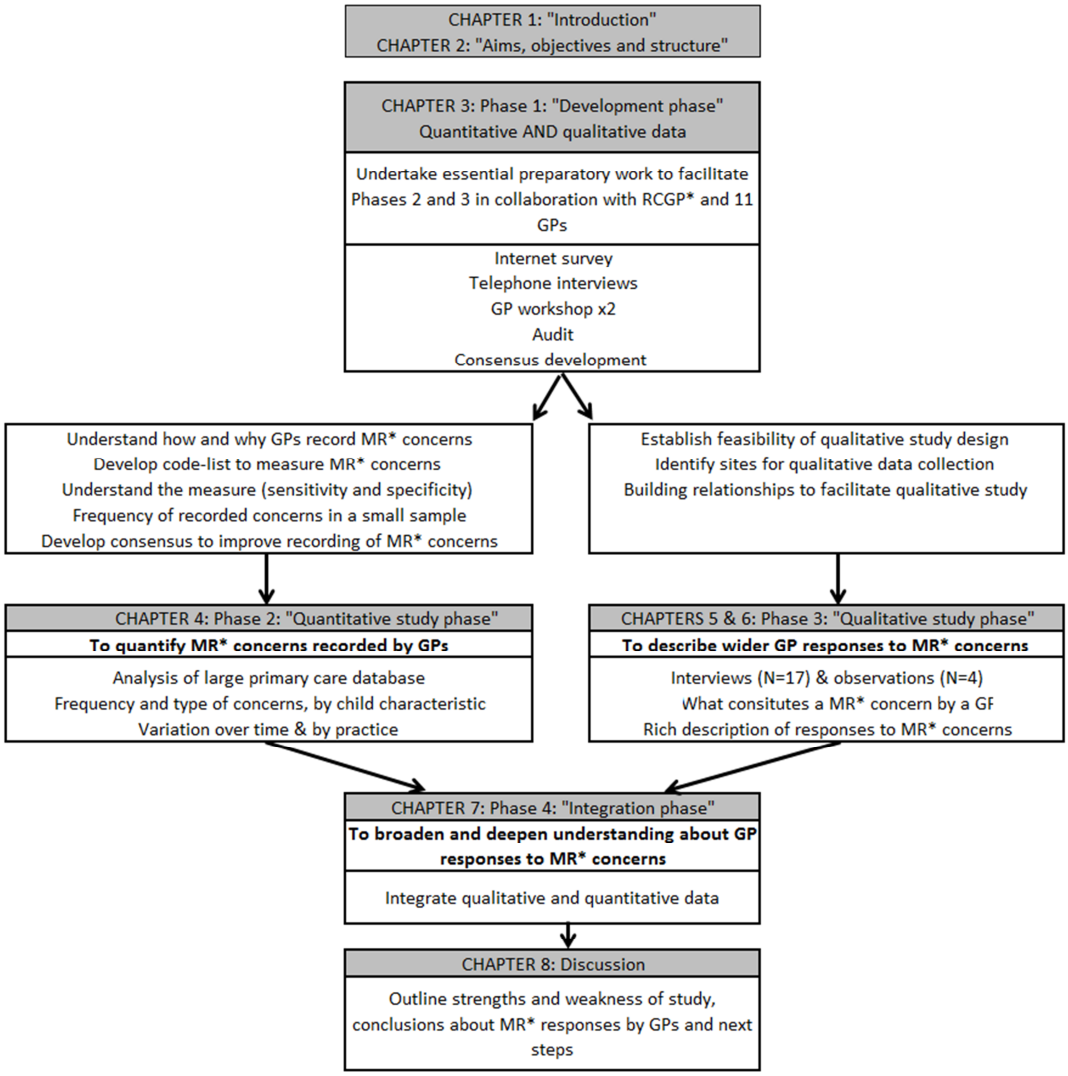
Chapter 6: Results from qualitative interviews and observations

Chapter 7: Integration of findings from epidemiological and qualitative analyses

Chapter 8: Discussion and implications for entire PhD thesis.

The chapters reporting the quantitative phases of the study (phases 2 and 3, chapters 3 and 4) each contain methods, results and discussion. Due to length, the methods and results/discussion for the qualitative phase (phase 3) are split into two chapters (Chapters 5 and 6).

Figure 2-2: Structure of PhD study, including thesis structure.



* RCGP = Royal College of General Practitioners; MR = Maltreatment-related

2.7 Key points from Chapter 2

- The primary aim of this PhD study was to describe and understand responses to maltreatment-related concerns by GPs in England.

- There were four phases to the study and each phase had its own objectives and methods.

- This study adopted a mixed methods design whereby I collected, analysed and integrated quantitative and qualitative data. The quantitative and qualitative components of the study ran concurrently and were kept analytically distinct until the final interpretation stage when the inferences from each were combined.

- By using a mixed methods design I hoped for additive benefit and aimed to increase the breadth of my study findings.

3 CHAPTER 3: Development phase of the study

Statement of authorship

The work presented in this chapter was the result of collaboration between UCL (Ruth Gilbert and myself), the Royal College of General Practitioners (RCGP), colleagues at the University of Surrey and 11 General Practices in England. I wrote the study protocol and designed, conducted and analysed the internet survey and telephone interviews with GPs. I also designed, organised and wrote up the workshops with GPs (only one of which is reported in this chapter). The RCGP recruited the 11 participating general practices and the study was conducted as a registered audit ('The RCGP multisite safeguarding audit' http://www.rcgp.org.uk/clinical-and-research/clinical-resources/clinical-audit/safeguarding-children-multi-site-audit.aspx)

Colleagues from the University of Surrey designed and conducted the data download from the 11 practices and analysed the data, with advice from RG and myself.

I have published much of the work presented in this chapter as a journal article (reproduced in Appendix 9.3) and it also informed a letter to the editor of the British Medical Journal.[1 2]

3.1 A note on collaborating with the RCGP

The work in this chapter is based on my work with 11 jobbing GPs from across England. These 11 GPs were recruited by the RCGP for an audit on child safeguarding in general practice, funded by the Healthcare Quality Improvement Partnership (HQUIP). The RCGP recruited GPs to this audit using a snowballing technique: GPs with a known interest in safeguarding or quality improvement were invited to participate and asked to identify other practices.

My involvement with the RCGP audit began after my supervisor (RG) was invited to a preliminary steering group meeting for the audit, which I also attended. At this stage academics with expertise in quality improvement in primary care from the University of Surrey were already on-board. My input to the project started at the protocol development stages of the audit.

The collaboration between myself, my supervisor (RG), the University of Surrey and the RCGP had two aims: first, to help the RCGP by giving them access to our epidemiological expertise and my time and secondly, I planned to use the data collected and the group of engaged and expert GPs to support the development phase of my PhD study. A principle aim of the RCGP was to improve recording of child safeguarding among the 11 GPs and to measure recording before and after the implementation of a quality improvement intervention. At the stage at which I began collaborating with the RCGP and audit group, the quality improvement intervention had not been defined. Myself and my supervisor (RG) suggested using qualitative methods to understand recording practices and consensus methods to develop an agreed approach to recording which could be implemented in the 11 practices (as a 'quality improvement intervention').

The resulting approach to recording recommended that GPs *always and as a minimum* use a single "child is cause for concern" code to flag a child who prompts maltreatment-related concerns. This simple approach to coding concerns is now recommended by the RCGP on a national level.

3.2 Content and structure of Chapter 3

In this chapter, I describe how I worked with the group of 11 GPs and employed multiple quantitative and qualitative methods to prepare for subsequent analyses of a large primary care database (phase 2, reported in Chapter 4) and qualitative data collection and analysis (phase 3, reported in Chapters 5 and 6). The multiple methods comprised: an online questionnaire survey, telephone interviews, two workshops, searches of Read code-dictionaries, database analysis and a validation exercise.

First, I describe the overall aim of the development phase and the characteristics of the 11 GPs and practices with whom I worked. I then report the background, methods and results for each of the six objectives within the development phase.

The chapter is divided into two main sections: objectives pertaining to the development of the routine primary care database analyses (phase 2) and objectives pertaining to the qualitative phase of the PhD study (phase 3). I end the chapter by drawing conclusions about how the findings contributed to the development of phase 2 and phase 3 of the PhD.

In this chapter, I report only methods and results which directly pertain to the development phase of my PhD study. Further work which I undertook using my PhD-funded time and as part of the collaboration with the RCGP and audit group is not reported in the main body of this chapter, notably:

- The new approach to coding, which was undertaken primarily to meet the goals of the RCGP. This is reported in Appendix 3.1. I have published the methods and results for the consensus development of the new approach to coding in full elsewhere[1] and materials to aid implementation of this approach at a practice-level are freely downloadable from http://www.clininf.eu/maltreatment.

- Detailed results of analyses of data collected from the 11 practices, including analyses by child age group and sex and by practice. I have published these results in full elsewhere.[1]

- Comparison of data before (Jan 2010-Dec 11) and after (Jan-Dec 2012) implementation of the new approach to coding in the 11 practices who participated in the development phase of my PhD. This has been written up as a manuscript which is currently under review (correct at time of writing in May 2014).[175]

3.3 Aim of the development phase

The primary aim of this phase was to undertake preparatory work to facilitate the analysis of a large routine primary care database (phase 2) and the qualitative study exploring the views and experiences of GPs in responding to maltreatment-related concerns (phase 3). Please refer back to Figure 2-2 in Chapter 2 for an overview of the study phases and how they fit together within the overall PhD study.

3.4 Characteristics of the 11 GPs and practices with whom I worked

3.4.1 Methods

Using an online questionnaire, I collected information about the characteristics of the 11 participating GPs and their practices to better understand how this group might relate to wider general practice in England. See method three in Table 3-1 for more details about the questionnaire and Appendix 3.2 for a full copy.

Table 3-1: Details of methods used in development stage (chronological order)

Method	Description	Partici-pants
1. Searches of Read code dictionaries (Jan-Feb 2010)	I conducted searches of Read code dictionaries to identify relevant Read codes. This involved: • Key word and code-stem searches of dictionary containing 5 Byte V2 Read code dataset (see Appendices 3.3 and 3.4 for list of keywords and code stems). • Keyword searches of NHS Connecting for Health's Clinical Terminology Browser (Triset) containing 4 Byte, V2 and V3 Read code datasets. Searches of Read code lists were supplemented by relevant codes recommended by the RCGP [87] and examples of clinical practice from the workshop (see method 4, below in this table). See Figure 3-1 for a diagram of the methods used to identify relevant Read codes and the numbers of codes at each stage. I incorporated feedback from two GP leads and my supervisors on the keywords and stem search terms and on a final draft of the code list. At the final feedback stage, 219 codes that related to health service use (e.g. health visitor involved), environmental risk factors codes (e.g. poverty, unemployment, asylum seekers) and codes relating to peer or community risk factors were excluded as the two expert GPs judged that these codes were not specific to maltreatment-related concerns.	2 GP leads

Table continued overleaf

Table 3-1: *Continued*: detail of methods used in development stage

Method	Description	Partici-pants
2. Telephone interviews (April-May 2010)	I conducted 10 minute telephone interviews between 26th April and 12th May 2010. The interviews were arranged via email and I asked each GP to have in mind three children registered at their practice who had specific characteristics related to maltreatment (see Appendix 3.5 for email template): • A child who is a current cause for concerns due to safeguarding issues. • a child who is (or has been) looked after (i.e. in local authority care). • a child who is currently in contact with children's social care. During the telephone interview, the GPs viewed the relevant child's electronic health record and described how the safeguarding concerns had been recorded for each of the three children. I made notes during the interviews to capture comments. The interviews were not audio-recorded.	9 GP leads, 25 children discussed
3. Online questionnaire (April-May 2010)	I designed an online questionnaire, completed by GP leads between April and May 2010, with 14 questions covering relevant professional experience and training, practice software, number of staff, and practice team meetings to discuss vulnerable families (see Appendix 3.2 for the full questionnaire).	14 GP leads

Table continued overleaf

Table 3-1: *Continued*: detail of methods used in development stage

Method	Description	Partici-pants
4. Workshop (May 2010)	I organised a half day workshop for the 11 GP leads in London in May 2010. Eight of the GP leads attended and one joined by phone. The GP leads each chose one child from their practice (or young person or family) about whom there were "concerns about child maltreatment". Using this child as a case study, each GP gave a five minute presentation on the nature of the concerns, how the problem came to the GP's attention, actions taken and how the concerns and actions were recorded. Each presentation was followed by approximately 10 minutes of free-ranging discussion about issues raised by the case study. I made notes during the workshop and used these to draw up a table of themes which I circulated to the 11 GP leads and amended in response to their comments (see Appendix 3.6 for full copy of this report). The workshop was audio-recorded for archiving but I did not use the recording for analysis.	9 GPs leads

Table continued overleaf

Table 3-1: *Continued*: detail of methods used in development stage

Method	Description	Partici-pants
5. Analysis of data from 11 practices (Jan-Apr 2011)	Colleagues at the University of Surrey calculated the rates of a) any maltreatment-related code and b) codes relating to child protection procedures (2009-2010) and 95% CI (confidence intervals) were estimated using the Poisson distribution. The denominator population was based on children aged under 18 years who were registered for any length of time between 1st January 2009 and the date of data download at each practice (10/9/2010 – 17/9/2010). Person years at risk were calculated by taking the interval from the latest of: 1st January 2009 or date of registration until the date of data download at each practice. The numerator comprised children at least one relevant code in the same time period. Duplicate children and any maltreatment-related records that occurred outside the defined period at risk were removed. Rates were age adjusted. Age adjustment related to the overall study sample (not an external reference population) and was based on relative frequency of children within four age groups (<1; 1-4; 5-11; 11-<18). I provided a spread sheet of the 350 codes to colleagues at the University of Surrey who developed a query that could be run on the in-house system at each of the 11 practices. Data were retrieved by a technician and stored in encrypted format. One practice was removed due to problems with the data download.	10 practices

Table continued overleaf

Table 3-1: *Continued*: detail of methods used in development stage

Method	Description	Partici-pants
6. Validating the Read code list (Sept 2011)	I conducted a validation exercise to gain insight into the sensitivity and specificity of the maltreatment-related codes I had identified. For this exercise, each of the 11 GP leads was asked to review each of the children in their practice who had one or more maltreatment-related codes and, using a combination of the child and parent records and their own knowledge about the family, they were asked to judge whether each child met thresholds for "consider" or "suspect" maltreatment as defined in NICE guidance (see Table 1-2 in Chapter 1 for detail of these thresholds). This was done for all codes except those relating to child protection procedures, which I assumed to be specific to child maltreatment due to the high threshold for receipt of these services.[66] Only three of the GPs completed this validation task despite two email reminders.	3 GPs

3.4.2 Results

The 11 practices were based across England, with a concentration in the South East. Three practices had health visitors on-site and all but two of the practices held meetings with the specific purpose of discussing families identified as vulnerable (including those with maltreatment-related concerns). These meetings are recommended by the RCGP and can be taken as a mark of good practice in this area.[87]

As might be expected from a convenience sample of GPs participating in an audit in the area of child safeguarding, there was a high level of relevant expertise and specialist interest among the 11 lead GPs. Four GP leads were named child protection doctors and/or involved in developing policy or delivering training in child protection.

Both the lead GPs and their practices can be considered to have more than average child safeguarding expertise and interest; in this respect they are not likely to be representative of the wider GP population in England.

See Chapter 3, Table 3-2, p. 111 for more detailed characteristics of the lead GPs and their practices.

Table 3-2: Characteristics of the 11 participating GP practices and GP leads

Site ID	Location (England)	Electronic System	FTE GPs*	Health visitors located in practice?	Meetings to discuss vulnerable families: frequency and attendance**		Relevant expertise of lead GP***
1	North East, suburban	INPS Vision	4	Y	Regular	GP, PN, HV	Child protection
2	East Midlands, semi-rural	TPP Systm1	4	N	Regular	GP, PN, HV, Edu. LSCB	Child protection
3	East, urban	EMIS LV	6	N	Regular	GP, PN, HV	Child protection
4	South East, semi-urban	TPP Systm1	3	Y	Regular	GP, PN, HV	Child protection
5	South East, urban	INPS Vision	3	Y	Regular	GP, PN, HV	-
6	South East, semi-urban	Isoft Synergy	4	N	Not held	GP, PN, HV	Other
7	South East, semi-urban	EMIS PCS	6	N	Regular	GP, PN-, HV, CPN, DN	Other
8	South East, semi-urban	INPS Vision	11	N	Not held	-	-
9	South East, semi-urban	INPS Vision	5	N	Ad hoc	GP, PN	Other
10	South East, urban	EMIS LV	4	N	Ad hoc	GP, PN, HV	-
Excl	South east, semi-urban	EMIS LV	3	N	Not held	-	-

*FTE GPs: number of full time equivalent GPs at practice.
**GP=general practitioner; PN=practice nurse; HV=health visitor; Edu=safeguarding leads from local schools; LSCB=Local Safeguarding Children's Boards child protection coordinator; CPN=community psychiatric nurse; DN=district nurse.
***Child protection=the lead GP at the practice was a child protection expert (named child protection doctor and/or involved in child safeguarding policy and/or delivers child safeguarding training). Other=expertise included experts in primary health care informatics, quality improvement and ethics).

3.5 Development for phase 2 (analyses of primary care database)

3.5.1 Background: why did I need development work?

Routine primary care data consists of anonymised electronic patient records containing information that is recorded by GPs, practice nurses or practice administrators. The information is recorded using structured codes, free-text or uploaded documents. Free text entries are very idiosyncratic and difficult to collate on a population basis which means that researchers usually rely on coded data when analysing primary care data for population-health research.

All practices in the UK use the Read code system, a hierarchical coding system for recording of clinical consultations and patient management.[176] There are different versions of Read codes: the majority of GP practices use Version 2 (5 byte) with a minority using other sub-types, including Read Clinical Terms CVT3 and the systematised nomenclature of medicine clinical terms (SNOMED CT).[177] The primary care database which I planned to use in phase 2 of my PhD contained only Version 2 5 byte Read codes. However, to make the development phase of my PhD study useful to the RCGP and wider GPs, I included also included CVT3 and SNOMED CT in this initial phase of my PhD.

As the primary purpose of the primary care data is for the clinical management of patients, using Read codes for research purposes is not straightforward. Clinicians see coding as a complex sociotechnical issue that is part of their relationship with the patient.[178] For conditions which are poorly defined, difficult to diagnose with certainty and are associated with social stigma, GPs balance the benefits of coding against the perceived harms, namely distress to the patient or disruption of the patient-doctor relationship if/when the record is seen.[178] A study which conducted focus groups and interviews with 34 parents who had "concerns about the mental health" of their children reported that fear of receiving a long-lasting and stigmatising label deterred parents from seeking help from their GP.[179]

For such conditions which do not fit neatly into a biomedical model, coding is seen as problematic[178] and child maltreatment has all the characteristics of such a condition. The desire to avoid using unnecessarily stigmatising and potentially harmful codes can lead to variation in the types of codes used and the use of indirect or euphemistic codes by GPs. This is illustrated by another study about mental health problems: a study of recorded depression in UK primary care practices found an increasing rate of non-specific ("symptom") codes in consultations related to adult depression over time compared to a decreasing rate of more specific "diagnosis" codes.[180]

Because of disincentives to label child maltreatment (explained in Chapter 1, section 1.4.1.2.4, p.51) and incentives to use indirect or euphemistic codes, a sufficiently sensitive measure of maltreatment-related Read codes must also include codes which do not refer directly to child maltreatment or to child protection. Deciding which broader codes should be included in the outcome measure requires careful thought and significant practitioner input. However carefully it is devised, the Read code list will inevitably be an imperfect measure of both maltreatment concerns in primary care *and* those that are recorded. To sensibly interpret the results of analyses using a Read code list as an outcome measure, the researcher should acquire an understanding of recording behaviour and its meaning in the relevant clinical setting and should have a grasp on the likely sensitivity and specificity of their Read code list outcome measure.[181] In my PhD study, I used the development phase to gain this understanding.

3.5.2 Overview of objectives

1. To understand how and why GPs record concerns about child maltreatment.
2. To develop a Read code list to measure maltreatment-related concerns in children's primary healthcare records.
3. To gain insights into the sensitivity and specificity of this outcome measure.

4. To test whether the maltreatment-related Read code list worked to identify any children in primary care data.

In the following sections I report the background, methods and results for each of these four objectives. In Table 3-3 I present an overview of the relationship between the objectives and the methods used.

Table 3-3: Relationship of objectives and methods in development phase

Objectives	Methods					
	Searches of Read code dictionaries (Jan-Feb 2010)	Telephone interviews with GPs (Feb-May 2010)	Online question-naire (Apr-May 2010)	Workshop with GPs (May 2010)	Analysis of data from 11 practices (Jan-Apr 2011)	Validating the Read codes (Sept 2011)
1. To understand how and why GPs record concerns about child maltreatment.		■		■		
2. To develop a code list to measure maltreatment-related concerns in children's primary healthcare records.	■	■		■		
3. To gain insights into the sensitivity and specificity of this outcome measure.		■				■
4.To test whether the maltreatment-related Read code list worked to identify any children in a small sample of primary care data.			■		■	
5. To gain a better understand of whether the design of the qualitative study (Phase 3) was feasible and likely to generate rich				■		
6. To select sites for qualitative data collection, understand GP culture and build gatekeeper relationships to facilitate access.			■	■		

3.5.3 Objective 1: understanding recording of concerns

To understand how and why GPs record concerns about child maltreatment

3.5.3.1 Methods

I used telephone interviews and a workshop with the group of 11 GPs to gain insights into how and why GPs record concerns about child maltreatment. See Table 3-1 (methods 2 and 4) for a detailed explanation of the telephone interviews and workshop.

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3.5.3.2 Results: how do GPs record concerns?

The type and completeness of recording for children with known maltreatment-related problems was highly variable. In the telephone interviews, GPs discussed 25 children out of a possible 27 (i.e. two GPs only provided two rather than the requested three cases-studies). Six of the 25 children did not have any relevant Read codes in their records while one child had 10. GPs described the use of frequent and extensive free text entries in the children's records and the presence of scanned documents, such as child protection plans or correspondence from A&E. Five of the six children without Read codes had relevant free text entries or relevant scanned documents in their records. One child did not have any indication of concern, except a letter from A&E detailing an injury attendance which was only significant in the context of the unrecorded maltreatment concerns.

In the telephone interviews, many Read codes that the GPs described to me by the GPs as "relevant" were not specific to maltreatment and the accompanying free text comments had been used to specify the child protection concerns. For example, the two instances of the Read code "Third party encounter" had accompanying free text which described a) an Emergency Department visit for a suspicious injury and b) the outcome of a child protection medical conducted by a paediatrician. This use of free text with non-specific codes was confirmed by the workshop in May 2010 where one GP described routinely using the code "had a chat" with a free text entry in order to indicate concerns about parenting capacity.

Four of the children in the telephone interviews had some form of "alert" about child protection concerns which discreetly appeared on the screen when their record was opened. Because these alerts did not form part of the child's permanent health record, they would not be contained in the large primary care database that I analysed in phase 2. During the workshop in May 2010, GPs explained that alerts had the advantage of being immediately visible to practice

staff without being visible to the patient either during consultation or if they later requested a copy of their health record. Using alerts also avoided the difficulties of attributing a permanent Read code to an uncertain judgement about a family. Recording concerns as an "active" or "significant" problem was another technique used to ensure visibility on screen; these entries do form part of the permanent health record and would be available to researchers using routine primary care databases.

The workshop emphasised how difficult the GPs found recording maltreatment-related concerns (see Appendix 3.6 for full details of discussion at the workshop). There was a perceived risk of damaging either the relationship between family members or between the GP and the family if the records were seen by the patients. The GPs agreed that it was easier and more acceptable to record "hard facts" such as child protection plans rather than judgements. One GP described how she dealt with the difficulty of recording judgements by observing and recording parent-child interaction to prevent the recorded concern sounding like "gossip". There was legal and ethical confusion over the acceptability of recording third party information in a child's record. For example, a desire to preserve patient confidentiality resulted in a situation where parental drinking problems (that was affecting parenting) was well documented in the mother's records but was not mentioned in the child's. At the time of the workshop, the GMC had not yet published its guidance clarifying that concerns should be recorded in the records of all relevant family members.[130]

3.5.3.3 Results: why do GPs record concerns?

The GPs agreed that recording information in a structured way (using Read codes) was important for ensuring that children were "findable" on the system and for ensuring that other GPs, including new/locum GPs are aware of existing concerns without having to read large amounts of text (i.e. to provide continuity

of care between GPs). The three GPs who discovered a lack of relevant Read codes in the child's notes during the telephone interview seemed uncomfortable with this discovery and expressed concern about the absence of codes. GPs described how free text entries helped with interpretation of Read codes and could be used for risk assessment and requests for information from children's social care e.g. case-conference reports.

Box 3-1 summarises the main issues about recording that arose from the workshop and telephone interviews.

Appendix 3.6 gives a detailed summary of the main themes discussed at the exploratory workshop and Appendix 3.7 reports the complete results of the telephone interview for each of the 25 children discussed.

Box 3-1: Recording of maltreatment-related concerns: key messages from workshop and telephone interviews

- Under-coding of known concerns was relatively common. Lack of any relevant recording for known concerns also occurred.
- The GPs saw codes and free text as having different purposes: both are needed.
- Coding was perceived as essential for searchable records and to ensure that information about maltreatment concerns carried over to the next GP or next practice.
- The GPs described how interpretation of the record was affected by who enters the code or text (i.e. GP or Health visitor or administrative staff).
- The GPs believed that visibility of maltreatment concerns on the screen might be damaging to the therapeutic relationship with the family.
- The GPs were concerned about confidentiality requirements when recording third party information (e.g.: relating to parents or siblings) but agreed that it was very important information affecting the child's risk status.
- The GPs stated that recording should favour events, observations and findings over opinions.
- The GPs described how they were not but should be routinely informed about children referred to children's social care by other professionals.
- In the GPs' opinion, children followed up by health visitors and school nurses for maltreatment concerns should be coded in the GP record.
- The GPs agreed that recommendations for coding cannot be comprehensive. The best type of recommendations should offer a framework for coding that is feasible to implement, easy for GPs to remember and does not risk "putting off" less experienced GPs.

3.5.4 Objective 2: developing a Read code list

To develop a Read code list to measure maltreatment-related concerns in children's primary healthcare records

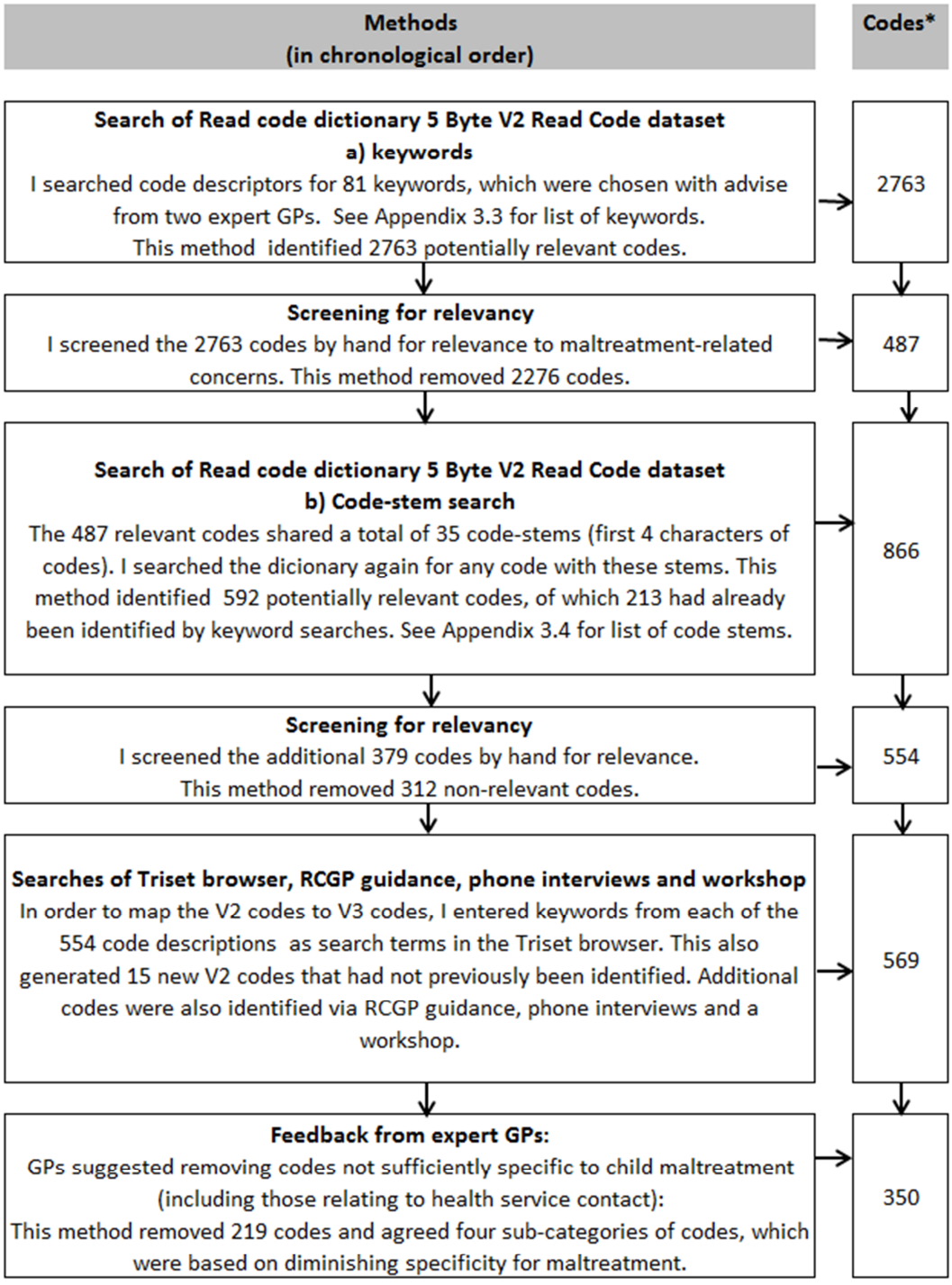
3.5.4.1 Background

I aimed to create a Read code list that would identify concerns about child maltreatment which met a minimum threshold for action, equivalent to a threshold of "consider" maltreatment as described in the NICE guidance.[128] See Chapter 1, Table 1-2, p. 35 for a description of this threshold. By aiming to develop a code list that met the "consider" threshold, I was aiming for an outcome measure which included the whole spectrum of maltreatment-related concerns. As explained in Chapter 1, 1.6.1, p. 62, this is consistent with guidance from the GMC, who recommend that even "minor" concerns be recorded.[130]

3.5.4.2 Methods

Combining iterative searches of Read code dictionaries with expert GP feedback is an accepted methodology for developing lists of Read codes to measure health outcomes in primary care databases.[182] Given the particular difficulties of defining and measuring maltreatment-related concerns using Read codes, I extended this methodology to include codes recommended by the RCGP in their existing guidance[87] and suggestions for relevant codes from the clinical practice of the 11 lead GPs from the audit group. Examples of codes used in clinical practice were taken from telephone interviews and workshops (see Table 3-1 for detailed methods of interviews and workshop).Figure 3-1 gives an overview of methods for identifying relevant codes in chronological order, including numbers of codes added or removed at each stage.

Figure 3-1: Summary of methods for developing code list to measure maltreatment-related concerns in routine primary care dataset



* Running total, de-duplicated.
V2 =Version two; V3 = Version three

3.5.4.3 Results

As Figure 3-1 shows, the final code list comprised 350 maltreatment-related Read codes. The majority of codes (339; 96.9%) were identified through searches of the Read code dictionary and only a handful of extra codes (11; 3.1%) via the telephone interviews, workshop and Triset browser searchers.

I grouped these 350 codes into four subcategories:

- child protection procedures
- direct references to maltreatment and out-of-home care
- "high risk child"
- contact with children's social care (child protection not specified)

The four categories were developed based on two factors:

- my common sense understanding of the codes. For example, it made sense to me that codes describing child protection procedures within children's social care should be grouped together (e.g: "child subject to child protection plan", "multidisciplinary case conference" and "on child protection register").
- It was less obvious how the less specific codes should be grouped. A guiding principle that I used was a diminishing certainty that maltreatment had been considered by GPs (i.e. we can be more certain that a code describing a child protection procedure relates to a concern about maltreatment than we can about a code describing a "vulnerable child" (in high risk category). I adopted such an approach based on studies that had successfully used this method to develop coding categories for estimating child maltreatment-related concerns in routine data on hospital admissions in England.[183]

The categories were iteratively revised and codes were moved from one category to another based on feedback from two GPs and my supervisors.

Table 3-4 gives a more detailed description of the four subcategories and shows the most commonly used Version 2 Read codes within each subcategory.

Appendix 3.8 contains a complete list of the 350 Version 2 Read codes in each of the four subcategories.

Table 3-4: Examples of maltreatment-related codes

(Version 2 Read codes used at least 50 times in The Health Improvement Network database in 2009-10, in descending order of frequency)

Category (N of codes in category)	Example Read codes	
Child protection procedures (N=24) Codes indicating child protection plan, case conference, or child protection investigation. Child protection plans are UK statutory child protection services, equivalent to "substantiated" maltreatment in North America.[184]	13IM.00	Child on protection register
	Z35..00	Child protection procedure
	3875.00	Social services case conference
	8CM6.00	Child protection plan
	64c..00	Child protection procedure
	3874.00	Multidisciplinary case conference
	13Id.00	On child protection register
	Z331.00	Child protection plan
	13IC.00	Register
	Z352.00	Child protection investigation
	13Iv.00	Subject to child protection plan
	9F2..00	Child at risk-case conference
Direct references to maltreatment or out-of-home-care (N=129) Codes explicitly referring to maltreatment or formal out-of-home care. At March 2013 91% of Looked After children were in out-of-home care due to abuse or neglect, "acute family stress", "family dysfunction" or "absent parenting".[185]	13VF.00	At risk violence in the home
	13IB00	Child in foster care
	13IV.00	Looked after child
	6982.00	Fostering medical examination
	38C0.00	Child in care health assessment
	13ZV.00	At risk of neglect by others
	13ZT.00	At risk of physical abuse
	13IB.00	Child in care
	13HP600	Violence between parents
	13ZR.00	At risk of emotional abuse

Table continued overleaf

Table 3-4 *Continued*: Examples of maltreatment-related codes

Category (N of codes in category)	Example Read codes	
High risk child (N=131) Codes indicating high levels of social welfare need or concern in the child or family, including a history of abuse or neglect.	1BE1.00	Problem situation
	13IF.00	Child at risk
	13IS.00	Child in need
	13If.00	Child is cause for concern
	14X3.00	History of domestic violence
	13IF.1100	Vulnerable child
	13IQ.00	Vulnerable child in family
	625..00	A/N care: social risk
	13W..11	Family problems
	8CM5.00	Child in need plan
	13Ip.00	Family is cause for concern
	14XD.00	History of domestic abuse
	13IF.00	Child at risk
	13IS.00	Child in need
	13If.00	Child is cause for concern
	14X3.00	History of domestic violence
	13IF.1100	Vulnerable child
	13IQ.00	Vulnerable child in family
	625..00	A/N care: social risk
	13W..11	Family problems
	8CM5.00	Child in need plan
	13Ip.00	Family is cause for concern
	14XD.00	History of domestic abuse

3.5.5 Objective 3: sensitivity and specificity of Read code list

To gain insights into the sensitivity and specificity of the outcome measure

3.5.5.1 Background

From the beginning, I was aware that my Read code list would not capture all maltreatment-related concerns known to general practice (i.e. it will not be 100% sensitive). In addition, because I included a broad range of codes in my outcome measure, it may be that the code list identified children about whom there was in fact no maltreatment-related concern (i.e. it might not be specific). For example, a disabled child could feasibly have a "vulnerable child" code in the absence of any concerns about parenting or ill treatment. To interpret any results from phase 2 (generated using my maltreatment-related Read code list), I first needed to gain further insights into the sensitivity and specificity of my outcome measure.

3.5.5.2 Methods

There are several ways that researchers can gain insight into the relationship between coded data and true diagnoses or, in this case, professional concerns about child maltreatment. Because it does not rely completely on the record which contains the coded data, one of the more robust methods might be to ask GPs for further information about patients.[186] I used telephone interviews and a validation exercise to request this extra information from the lead GPs and contextualised it using findings from the workshop in May 2010 (see Table 3-1 for methods of validation exercise, interviews and workshop).

3.5.5.3 Results

The telephone interviews revealed that many children with known concerns in the 11 practices did not have relevant Read codes in their records and this finding was supported by the discussion in the workshop. Of the 25 children discussed in the telephone interviews, six (24%) did not have any relevant Read

codes in their record. This means that however careful I was to include all possible codes, my Read-code list is unlikely to be a sensitive measure of maltreatment-related concerns known to GPs.

However, the validation exercise revealed that my code list was very specific to children who had prompted concerns about maltreatment. Of the 42 cases validated by three GPs, 40 (95.2%) met thresholds for "suspected" maltreatment and two (4.8%) for "considered" maltreatment (see Chapter 1, Table 1-2, p. 64 for thresholds of consider and suspect). In the context of the high thresholds for recording concerns about child maltreatment that were clear from the workshop, it makes sense that a seemingly non-specific code such as "poor social circumstances" did in fact represent a true maltreatment concern from a GP.

3.5.6 Objective 4: trialling the Read code list

To test whether the maltreatment-related Read code list worked to identify any children in primary care data

3.5.6.1 Background

In view of the significant barriers to using Read codes to permanently record maltreatment-related concerns in the child's electronic health record, it seemed wise to test whether or not the Read code list that I had developed worked to identify any children within the 11 practices participating in the audit. If the codes I had identified were not used in the 11 practices, it might not represent a good use of time to undertake analyses of a very large and complex routine primary care dataset using the same code list in the way that I had planned (phase 2).

3.5.6.2 Methods

Colleagues from the University of Surrey developed a query based on my list of 350 maltreatment-related codes, ran this query at the 11 practices and used the data to calculate rates of maltreatment-related codes in children registered

between 2009 and 2010. One practice was excluded due to a problem with data download.

Rates were calculated overall and by type of software used at the practice. As the routine primary care database that I planned to use in phase 2 contained data only from practices using Vision software, it was important for me to verify that maltreatment-related codes were recorded in practices using this system. See Table 3-1 (method 5) for more details about how rates were calculated.

3.5.6.3 Results:

The study population from the 10 included audit practices comprised 24,939 children observed for a total of 40,627 child years at risk (mean 1.5, median 1.7 years). There were 316 children (1.3%) who had at least one maltreatment-related code entered in their record between 2009 and 2010.

The rate of any maltreatment-related code adjusted for age was 8.4 per 1000 child years at risk (95%CI: 7.5, 9.3), which was more than twice as high as the rate of any child protection procedure code in the same sample during the same time period (See Table 3-5). From this we can conclude that both specific and less specific codes were used (for different children) in the 10 practices during 2009 to 2010.

Given the smaller numbers, there was higher uncertainty (wider confidence intervals) around the rates when stratified by software type and especially so for Isoft which was only used by one practice (see Table 3-5).

The four practices using Vision software used maltreatment-related codes in 2009 to 2010 and at a rate which was similar to that of the EMIS and TPP practices (see Table 3-5).

Table 3-5: Rates of maltreatment-related codes in 10 practices (2009-10)

	Any child with one or more maltreatment-related codes:	Any child with a code reflecting a child protection procedure
10 practices 2009-10 England: 24,939 children <18y; 40,627 years at risk; 316 children ≥1 maltreatment-related code.		
Overall (adjusted for age)	**8.4 (7.5, 9.3)**	**3.2 (2.7, 28.2)**
Software type		
INPS Vision (4 practices)	9.6 (8.2, 11.1)	3.8 (3.0, 4.8)
Emis LV (3 practices)	7.7 (6.1, 9.5)	4.0 (2.8, 5.2)
TPP (2 practices)	9.4 (7.0, 12.0)	0.5 (0.1, 1.3)
Isoft (1 practice)	2.8 (1.4, 46.9)	2.0 (0.8, 3.5)

3.6 Development for phase 3 (qualitative data collection and analysis)

3.6.1 Background: why did I need development work?

High quality qualitative research relies on an understanding of the culture of those who are the subject of enquiry and an appreciation of the context in which they live (or, in my case, work). Talking about conducting qualitative research in another country, the medical sociologist Judy Green summarises the importance:

> "Qualitative work ideally requires fluency in the language and culture of the research setting." (p.98)

The sentiment can equally be applied to the skills that a non-clinical researcher (such as myself) needs to unlock meaning when collecting data from a professional "tribe" such as that of GPs:

> "If the interviewer is a complete "alien" and all aspects of the encounter are problematized, there is little opportunity to develop the trust and rapport needed for successful interviewing and for collaboratively generating meaning from the encounter."[159] (p.101)

When I started my PhD, I was a complete "alien" to GP culture and without any proficiency in their professional language or culture. The development phase of my PhD was designed to expose me to the language and culture of GPs in the context of child safeguarding so that I could go on to successfully recruit participants from this setting, collect rich data from the interviews and generate meaning from analyses.

3.6.1.1 Recruiting participants

It was clear from the beginning of my involvement with the RCGP audit that I could use some of the lead GPs as gatekeepers to their own GP practice or to other practices.

"Key informants" or "gatekeepers" can provide access to a community for a researcher that would otherwise be difficult to access. Although focussed on using gatekeepers to access research participants in a "foreign" community, much of Kawulich's writing on gatekeeping is relevant to my use of the GP leads to gain access to of the GP community. As Kawulich explains, a successful researcher-gatekeeper relationship relies on the gatekeeper perceiving that the researcher can observe his/her community's social norms and has good intentions towards the community.[187] The gatekeeper' s trust has to be earned by the researcher. My involvement with the RCGP audit, working towards their goals, was not so far from the long periods spent chatting and peeling sackfuls of potatoes that Kawulich describes as a necessary part of familiarisation between her and her Muscogee (Creek) gatekeeper.[187]

3.6.1.2 Producing meaningful data

In the development phase, through contact with the 11 GPs, I sought an understanding of GP culture, both generally and in the area of child safeguarding. I envisaged that this would allow me to conduct interviews using accepted tone and shared vocabulary, or as Rice and Ezzy put it "in their own language. [188 (p.59)] From this understanding of relevant GP culture, I also aimed to maximise the meaning that I could generate from analysing the qualitative data.[159]

3.6.2 Overview of objectives

Numbering continued from objectives for Phase 2 (of which there were four):

1. To gain a better understand of whether the design of the qualitative study was feasible and likely to generate rich data.
2. To select sites for qualitative data collection, understand GP culture and build gatekeeper relationships to facilitate access.

3.6.3 Objective 5: feasibility of qualitative study design

To gain a better understand of whether the design of the qualitative study was feasible and likely to generate rich data

3.6.3.1 Background

My provisional interview design relied on my participants being able to easily identify families who had prompted maltreatment-related concerns in their professional practice and to be able to discuss these cases in-depth and at length from memory, without mentioning any identifying features (such as names, schools, or place of work).

If my participants were unable to identify or discuss relevant cases from memory, the interviews would likely be short and the collected data superficial. If the participants were unable to discuss cases without (accidentally) mentioning identifying details, then the provisional design could be considered unethical (unless consent was gained from families which would be impractical and potentially harmful to the GP-patient relationship).

I used the development phase of my PhD to test whether the participating GPs could provide in-depth discussion of maltreatment-related concerns from memory and anonymously.

3.6.3.2 Methods

The workshop I conducted in May 2010 also relied on GPs being able to identify and discuss cases anonymously. If GPs could identify and discuss cases in-depth from memory and maintain patient anonymity during the workshop, I would assume that their colleagues would also be able to do so in face-to-face interviews. If not, I planned to rethink the design of my qualitative study. See Table 3-1 for workshop methods.

3.6.3.3 Results

In the workshop the GP leads demonstrated that they could identify relevant families from their clinical practice and could recall a high level of detail about them from memory. They were comfortable talking about the case histories and could do so without mentioning any identifying features of the families. The case histories presented by the GP leads in the workshop were a rich source of information for me and illustrated many themes. From the workshop, therefore, it seemed likely that the provisional design for the interviews was feasible, ethical and acceptable to GPs.

There were two additional points raised by the development stage that shaped the design of my qualitative study. First, GPs described how some concerns came to their attention via other professionals and how sometimes this should have been the case but was not. It seemed that the perspectives of other professionals would be useful in understanding the role of the GP. It was beyond the scope of my study to recruit participants from outside primary care but I made sure to include health visitors and practice nurses in my qualitative sampling frame.

Secondly, team meetings to discuss vulnerable families were often mentioned as a partial solution to some of the problems raised, including: isolation of GPs from health visitor and Education colleagues; and the need to monitor and manage families with chronic welfare problems over a long period of time. As these meetings seemed to be a key part of the GP response to child

maltreatment, I extended my qualitative data collection to include observations of these meetings.

3.6.4 Objective 6: identify qualitative data collection sites

To identify sites for qualitative data collection in Phase 3, understand GP culture and build gatekeeper relationships to facilitate access

3.6.4.1 Background

For the in-depth qualitative data collection of phase 2, I aimed to sample between three and five sites from the 11 practices. In order to maximise the chance of hearing about good practice examples of GP responses to concerns about child maltreatment, I planned to sample sites where the GP leads had most child safeguarding expertise and where team meetings were held (so I could observe them).

3.6.4.2 Methods

I used the online questionnaire to ascertain relevant characteristics of the 11 lead GPs and to gain details of meetings to discuss vulnerable families (see Table 3-1 for questionnaire methods). Based on these results, I selected four sites to approach regarding participation in my qualitative data collection. These four sites also represented a geographic spread across England.

More generally, I used the development phase and my work for the RCGP as an opportunity to create a situation where GP leads would be likely to agree to act as gatekeepers to their colleagues. I exchanged several emails with these GPs, met them at the 2010 workshop and became confident that they would be prepared to act as gatekeepers to facilitate my observations of meetings and interviews with their colleagues.

3.6.4.3 Results

There were several cultural and linguistic learning points that I took forward to the interviews. For example, I noticed that GPs consistently used words such as

"concerns" and "worries" without referring directly to child maltreatment or child protection or safeguarding. For example, one GP stated "there are very long-standing concerns about this family." There seemed to be a shared understanding of this language between the GPs.

I made an effort to mirror this language in my invitation to interview when recruiting, in the participant information sheet and in the interviews themselves. An appreciation of the shared language of "concerns" steered me towards unpicking the meaning of a "concern" in general practice via the in-depth qualitative work (reported in Chapter 6).

3.7 Ethics and research governance

The study of 11 practices was designed, registered and funded as an audit. Patient identifiable information (e.g. from telephone interviews and case study presentations) was accessed only by the patients' GP. No identifiable information was transferred outside the practices.

3.8 Discussion

3.8.1 How findings contributed to the development of phases 2 and 3

Based on the development phase, my measure of maltreatment-related records seemed sufficiently meaningful to use in analyses of a large routine dataset: although it is not a sensitive measure of all recorded concerns or all concerns known to GPs, it is specific and will provide a minimum estimate of children with maltreatment-related concerns known to GPs.

The database analyses suggest that GPs were coding maltreatment-related concerns. However, the numbers in the audit practices were too small to properly explore variation. This supports my plan to explore variation of recording over time, by child characteristic and by practice using a much larger primary care database (phase 2), reported in Chapter 4.

The development phase suggested that the 11 audit practices were actively managing children with known maltreatment-related concerns and that it was feasible and ethical to use interviews to collect in-depth data about how this was done (phase 3, reported in Chapters 5 and 6).

Following the development phase, I made some small changes to my qualitative study design:

- Including health visitors and practice nurses in my sampling frame.
- Also collecting data via observations of team meetings to discuss vulnerable families.
- Alterations to the language used when recruiting and collecting data.
- Aiming to unpick the meaning of “a concern” for GPs in the analysis.

3.8.2 Strengths and limitations

By including GPs in early stages of my study design, I maximised the chance that results of the study overall would be relevant and meaningful to practice. As

well as being useful for the overall design of my PhD study, the development phase generated recommendations for practice in terms of a simple approach to coding maltreatment-related concerns (reported in Appendix 3.1).

Given the commonly expressed view that the average GP lacks time, interest and expertise to engage in child protection,[61 122 124] the group of 11 practices is likely to have a higher than average expertise and interest in child protection. This probably contributed to the rich and informative discussion that occurred in the two workshops but also means that I should be cautious when generalising findings to a wider GP population. For example, rates of maltreatment-related code might be lower in a nationally representative sample.

The small numbers of participating GPs means that we cannot provide robust estimates of the sensitivity and specificity of our outcome measure, only insights into how far the measure may represent recorded (but not necessarily coded) concerns and known (but not necessarily recorded) concerns. The measure that I developed had low sensitivity for recorded and known concerns even among this group of relatively expert practices who were all in favour of improved recording in this area. Sensitivity of maltreatment-related codes may be even lower in a less expert sample of practices.

3.9 Key points from Chapter 3

By collaborating closely with the RCGP and 11 GPs, I undertook an essential preparatory ("development") stage for this PhD study in which I:

- designed and understood a measure of maltreatment-related concerns that could be used in subsequent analyses of routine primary care data (reported in Chapter 4). This measure is specific (but not sensitive) and will provide a minimum estimate of children with maltreatment-related concerns known to GPs.

- gained entry into the GP world, learned "their language", judged my qualitative study design to be feasible and identified potential sites for subsequent qualitative data collection and analyses (reported in chapters 5 and 6).

4 CHAPTER 4: Variation in maltreatment-related codes in primary care records

Statement of authorship

The vast majority of the work presented in this chapter was designed, conducted and interpreted by myself. The exception is the analysis of variation by practice. This part of the analyses was designed in collaboration with Nick Freemantle from UCL-Department of Primary Care and Population Health, who also carried out this part of the statistical analysis. Analyses that I carried out were conducted in Stata, version 11.2 (Stata Corp, College Station, Texas) and analyses by NF used SAS, version 9.2 (SAS Institute Inc, Cary, NC).

I have also published the work presented in this chapter as a journal article (reproduced in Appendix 9.4).[189]

4.1 Content and structure of Chapter 4

In this chapter, I describe how I used a large and representative UK primary care dataset (THIN: The Health Improvement Network database) to estimate variation in maltreatment-related codes over time, by child characteristic and between practices. To estimate incidence of maltreatment-related concerns and explore variation, I used the measure that I designed during the development phase of the PhD study (reported in Chapter 3). This is the first study to use a representative national sample to understand responses to child maltreatment in general practice. It is, therefore, the only study to-date from which we can generalise results to the wider GP population in England. I go on to summarise the main findings of the database analyses and interpret them in the context of existing literature and the strengths and weaknesses of this part of my PhD study. I end by outlining the key points from this chapter. Conclusions and implications for practice, policy and research can be found in Chapter 8.

4.2 Background

From the results of the development phase of this PhD study (Chapter 3, section 3.5.6.3, p. 129), we know that maltreatment-related Read codes *are* currently being used in at least some children's electronic primary care records. However, the analyses in the development phase of my PhD were limited by the small sample size and to-date very little is known about the frequency or types of maltreatment concerns on a national level and whether/how this may vary across children and practices. In this chapter I report further analyses of the large representative primary care dataset (THIN) in order to answer questions about the type of concerns that are coded and how the frequency of coding varies over time, by child characteristic and by GP practice.

4.3 Aims

To estimate variation in frequency and type of maltreatment-related codes in children's electronic health record in a large and representative sample of GP practices.

4.4 Objectives

To select a cohort of children from a large representative primary care database and describe the characteristics of the children in this cohort, including categories of coding in children with at least one maltreatment-related code.

To use this cohort to:

1. Estimate the frequency and type of maltreatment-related concerns recorded in children's electronic health records by comparing the incidence of maltreatment-related codes in 2010 by child characteristic (age, deprivation and sex) and type of maltreatment-related code.

2. Estimate variation of recorded maltreatment-related concerns over time and by practice in the same representative sample by:

- measuring the incidence of maltreatment-related codes by calendar year from 1995 to 2010 and describing trends over time.
- estimating between-practice variation of maltreatment-related codes in a representative sample of GP practices over three years (from 2008 to 2010).

4.5 Methods

4.5.1 Data source

Approximately 98% of the UK population is registered with a GP.[190] The Health Improvement Network (THIN) primary care database is one of the largest national collections of primary care data: in 2010 THIN contained data on over 10 million patients and covered 6% of the UK primary care population.[191] THIN is broadly

representative of the GP population in terms of patient demographics.[192] However, THIN contains slightly fewer patients aged under 25 years compared to the national GP population, the distribution of the male population in THIN matches slightly less well to the national population than the female population and THIN has a higher proportion of patients living in the most affluent areas than the national average.[192] Prevalence of codes for major conditions (e.g. asthma, stroke, diabetes) and mortality are similar to the broader GP population.[192] Diseases, symptoms, patient characteristics and problems are coded by primary care staff including GPs, nurses and administrative staff, currently using the Read version 2 system.[177] Diagnoses recorded by Read codes have moderate accuracy compared with reference clinical datasets for a range of conditions.[181] For each registered patient, deprivation is available in THIN in the form of quintiles of Townsend score, a composite measure of social deprivation that includes home ownership, overcrowding, car ownership, and unemployment. It is based on patient postcode and linked to UK census data from 2001 for approximately 150 households in each postal area.[193]

4.5.2 Study population

I included 448 practices that contributed data to THIN database for any length of time between January 1995 and December 2010 and which met the quality criteria of having Townsend score data for more than 80% of their registered patients aged under 18 years (reliant on practices recording patient postcode). I excluded 39 practices based on the Townsend quality criteria. Although the scope of this thesis is limited to England, the 448 practices came from across the UK and included 336 English practices, 20 North Irish practices, 61 Scottish practices and 31 Welsh practices. All 448 practices were included to maximise sample size with additional sensitivity analyses conducted to test whether results for the 336 English practices would have been substantively different from results for the total 448 UK practices (see section 4.5.10, p.149 for more on sensitivity analyses).

From the 448 practices, I included children aged up to 18 years who were permanently registered for any length of time between January 1995 and December 2010 and for whom there was date-of-birth and sex data (proxy for

quality of record). In THIN, the records of permanently registered patients have been subject to data quality checks and marked with a flag to indicate integrity of data for that patient (e.g. registration date is equal to or later than birth date). I limited my analyses to patients who had passed these data integrity tests. Data quality is poorer for temporarily registered patients, which is why they were excluded from this study. Time at risk started at the latest of: 1st January 1995, child's registration, or the year when the practice met criteria for acceptable quality of mortality recording.[194] The "acceptable mortality recording (AMR)" year is included in the files made available to researchers and is defined as the first year that the practice's reported number of deaths is as expected, according to national statistics and the demographic structure of the practice.[194] The effect of excluding time at risk prior to AMR year is minimal for recent years but it addresses the under-reporting of mortality in the mid-1990s, which was in the region of 30%.[194] It is logical to assume that if data quality is low for mortality recording in a practice, data quality will be poor for all conditions and the data providers of THIN recommend that AMR dates be applied as a filter for all cohorts which are being used to estimate incidence rates.

To avoid overestimating incidence by including diagnoses that occurred at a previous practice and which are entered onto the electronic primary care record shortly after registration at a new practice, researchers working with primary care data recommend excluding a period of time for each patient directly following registration.[195] The cut-off should be selected by plotting the rate of events per registered patient against time since registration and judging the time at which the rate levels off.[195] As the plots in Appendix 4.1 show, the rates of maltreatment-related codes began to plateau five months after registration at a practice. Based on these plots, I excluded the first five months of time at risk following registration for children who registered after their first birthday. As children registering before their first birthday are unlikely to have been previously registered at another practice, I did not apply the five month cut-off to this group of children. Time at risk ended at the earliest of: 31st December 2010; child's 18th birthday, child's transfer

out of the practice, child's date of death, or date when the practice stopped contributing data.

4.5.3 Identifying children with maltreatment-related codes

I used a Read code list to identify maltreatment-related codes. These 350 codes were designed as part of the development phase of the PhD study to capture clinical concern about possible, probable or confirmed maltreatment where concern reaches a minimum threshold for action, equivalent to a threshold of "considered" maltreatment as defined by NICE (see Chapter 3, Table 1-2, p. 64). The development of the code list and an assessment of its sensitivity and specificity are described in detail in Chapter 3, section 3.5.4, p. 121).

The main analyses were based on any maltreatment-related code in the child's primary care record, with sub-analyses based on the four subcategories of codes: 1) child protection procedures; 2) direct references to maltreatment or out-of-home care; 3) "High risk" child; and 4) contact with children's social care (see Chapter 3, Table 3-4, p. 125 for the most frequently used of these codes and Appendix 3.8 for complete list of codes, stratified by these four subcategories). Free text entries, which are idiosyncratic and difficult to collate on a population basis, were not available for this study.

4.5.4 Socio-demographic characteristics

I adjusted analyses for age, gender and deprivation (quintile of Townsend score) as these factors are known confounders for variation in maltreatment. I used five developmental age groups, <1 year, 1-4 years, 5-9 years, 10-15 years, 16-<18 years, which were also comparable with national data from the Department for Education.[196]

4.5.5 Missing data

I restricted analyses to children with complete age and sex data. Missing data for Townsend score were included in all analyses as an extra category of the deprivation variable. Because of the quality criteria applied when selecting

practices, all included practices had at least 80% complete Townsend score data for children <18y.

4.5.6 Descriptive analyses

To describe the cohort characteristics, I calculated the number of children and average time at risk, by sex, age group and deprivation quintile for children with and without a maltreatment-related code in their record. I also analysed patterns of coding during children's total time at risk by calculating the number of codes per child and numbers of children who had codes from more than one maltreatment-related subcategory and codes in more than one calendar year.

4.5.7 Variation over time

To examine variation in maltreatment-related codes in the time period between 1995 and 2010, I calculated percentage change in annual incidence and 95% confidence intervals (CI) for any maltreatment-related code and for the four subcategories. I divided the annual number of incident cases (first case per year per child) by the total child years at risk for each calendar year.

To generate the coefficients for annual percentage change, I fitted a negative binomial regression model for a log linear trend with a random intercept for practice, adjusted for sex, age category, and deprivation quintile and an interaction between age-group deprivation category. A negative binomial distribution was chosen over a Poisson distribution because the data did not meet the key assumption of a Poisson distribution: that the mean equals the variance (log likelihood ratio test for alpha=0 (p<0.0001); see Appendix 4.2 for more information on the test). Using a Poisson model in this instance is likely to underestimate standard error and therefore overestimate precision.

I based the model selection strategy on Akaike's information criterion (AIC) scores for the main outcome measure: any maltreatment-related code. I took a pre-defined difference of -9 (three standard errors) to indicate a substantially better model fit for this main outcome.[197] To avoid unnecessarily complicated analyses, I

planned to select the same model for the four secondary outcomes (subcategories of codes) as for the main outcome unless there was very strong evidence of a different trend in any of the secondary outcomes (indicated by a difference in AIC score of ≥27, equivalent to nine standard errors). See Appendix 4.2 for more details of the strategy I used to build the model, including AIC scores for each model.

The log linear model was selected over two other models: a basic linear model and a linear model with a 2005 change point. This change point model was tested because 2005 was the first full calendar year with pay for performance coding for some conditions in the UK following the introduction of the Quality and Outcomes Framework (QOF).[198] Some studies have shown that QOF (pay for performance) has increased coding for a range of diseases in adults, including diseases for which coding is not incentivised under the scheme.[199]

In order to take account of varying baseline rates of maltreatment-related codes in the practices, a random effects term was added to the model. This substantially improved the fit of the model: see Appendix 4.2 for AIC scores for the model with and without a random effects term.

Because the univariate analyses showed greater difference between deprivation quintiles in young compared with older children, I included an interaction term between age and deprivation, which substantially improved the model fit (see Appendix 4.2 for AIC scores for the model with and without an interaction term between age and deprivation).

4.5.8 Rates and rate ratios in 2010

To estimate differences in rates by child characteristic, I calculated rate ratios for sex and age and deprivation categories for annual incidence in the most recent year (2010). These analyses were based on a sub-group of children who were registered at any point in 2010.

In addition to incidence estimates, I calculated prevalence estimates for 2010. There were three purposes to this. First, to create a statistic that was more meaningful to clinicians as the denominator is based on children rather than the abstract concept of person years of registration (i.e. prevalence is equal to the proportion of all registered children in 2010 who had a maltreatment-related record). Secondly, to judge whether incident rates for infants were inflated due to delays in GP registration following birth, which could shorten the denominator without necessarily reducing the numerator. Thirdly, prevalence estimates also facilitated comparison of my results with results from existing literature and national data. Prevalence estimates were calculated by dividing the total number of children with a code in 2010 by the total number of children registered at any point in that year.

4.5.9 Between-practice variation in THIN 2008-2010

I grouped data for the three most recent years to examine current variation by practice (2008-2010). A three year period was chosen to maximise sample size whilst excluding historic data that would not be useful for making policy and practice recommendations. As I was interested in variation (not absolute measures), a logistic regression model was used to compare the prevalence of any maltreatment-related code between practices, adjusting for sex, age-category and deprivation quintile. The number of standard errors between the mean prevalence for each practice and the grand mean (mean of all 443 practices that contributed data between 2008 and 2010) was calculated. Outlying values were defined as those more than three standard errors (SEs) above or below the grand mean. In the event of outliers, I planned to adjust for over-dispersion using the Williams

approach (adding an extra variance component).[200] Taking account of the fact that events are not randomly distributed across practices (adjusting for over-dispersion) avoids false positive identification of outliers by producing more conservative estimates of precision.[201]

4.5.10 Sensitivity analyses

It is likely that vulnerable families move house and change GP more often than other families. By excluding temporarily registered patients from my population, I might have substantially underestimated the rate of codes across the child population in THIN.

Equally, it is possible that excluding the five months of time at risk following registration for all children except infants distorted my results. It might be that the different ways of defining time at risk inflated rates of maltreatment-related codes among infants compared to other age groups.

To maximise the sample size, I include practices from North Ireland, Scotland and Wales. Given the different policies across the UK (especially in Scotland),[10] my results might not be accurate for England, which was the focus of this PhD study.

To test these possible distortions in my results, I reanalysed data and calculated annual incidence rates in 2010 for any maltreatment-related code and the four subcategories of code with the following changes:

- including temporarily registered patients.
- excluding five months of time at risk for infants (as well as other age groups).
- including all time at risk since registration for all age groups conducted.
- only including the 336 English practices.

4.5.11 Ethics

The THIN scheme for obtaining and providing anonymous patient data to researchers was approved by the National Health Service South-East Multicentre

Research Ethics Committee (MREC) in 2002 and scientific approval for this study using THIN was obtained from the Medical Research Scientific Review Committee in May 2011 (see Appendix 4.3 for copy of approval).

4.6 Results

4.6.1 Descriptive analyses

Table 4-1 reports the characteristics of the cohort of children contributing data between 1995 and 2010. The 2008-2010 and 2010 subsets of data were similar in terms of the distribution of sex and deprivation, although the 2008-2010 subset had a lower proportion of young children compared to the other two. Full details of the 2008-2010 and 2010 cohort are available in Appendices 4.4 and 4.5.

Table 4-1: Characteristics of children in the 1995-2010 cohort

	1995-2010 448 practices contributed data ♠		
	Children ≥1 maltreatment-related code	**All children**	**Years at risk**
	N (%)		Sum (median)
All children	33,191 (2.1)	1,548, 972 (100)	7,460,888.6 (3.9)
Boy	16,169 (48.7)	800,141 (51.7)	3,868,999 (3.9)
Girl	17,022 (51.3)	748,831 (48.3)	3,591,890 (3.8)
<1y*	13,591 (40.9)	496, 049 (32.0)	2, 296, 494 (3.5)
1-4y*	7,125 (21.5)	290, 091 (18.7)	1, 798, 649 (5.5)
5-9y*	6,925 (20.9)	319, 429 (20.6)	1, 985, 803 (6.9)
10-15y*	5, 049 (15.2)	334, 221 (21.6)	1, 283, 161 (3.5)
16-17y*	501 (1.5)	109, 182 (7.0)	96, 747 (0.7)
Least deprived quintile†	3,620 (10.9)	363,277 (23.5)	1,969,740 (4.7)
2†	3,607 (10.9)	301,922 (19.5)	1,5202,54 (4.2)
3†	6,254 (18.8)	310,661 (20.1)	1,478,873 (3.8)
4†	9,282 (28.0)	304,551 (19.7)	1,373,370 (3.5)
Most deprived quintile†	9,678 (29.2)	231,473 (14.9)	1,006,997 (3.3)
Missing deprivation†	750 (2.3)	370,96 (2.4)	111,656 (2.1)

♠ The number of practices contributing data varies as each year a few practices leave the Vision system and a few join.
* Age at entry to study.
† Quintiles based on Townsend score for first registered address for child.

As shown in Figure 4-2, between 1995 and 2010 the majority of children with a maltreatment-related code only had one such code during their whole time at risk (85.7%; N=28,444). In the same time period, only 20.8% of children with any maltreatment-related code had such a code in more than one calendar year and 1.8% had a code in more than three calendar years (not necessarily consecutive years; see Figure 4-2).

Figure 4-1: Distribution of children with ≥1 maltreatment-related codes in their total time at risk 1995-2010

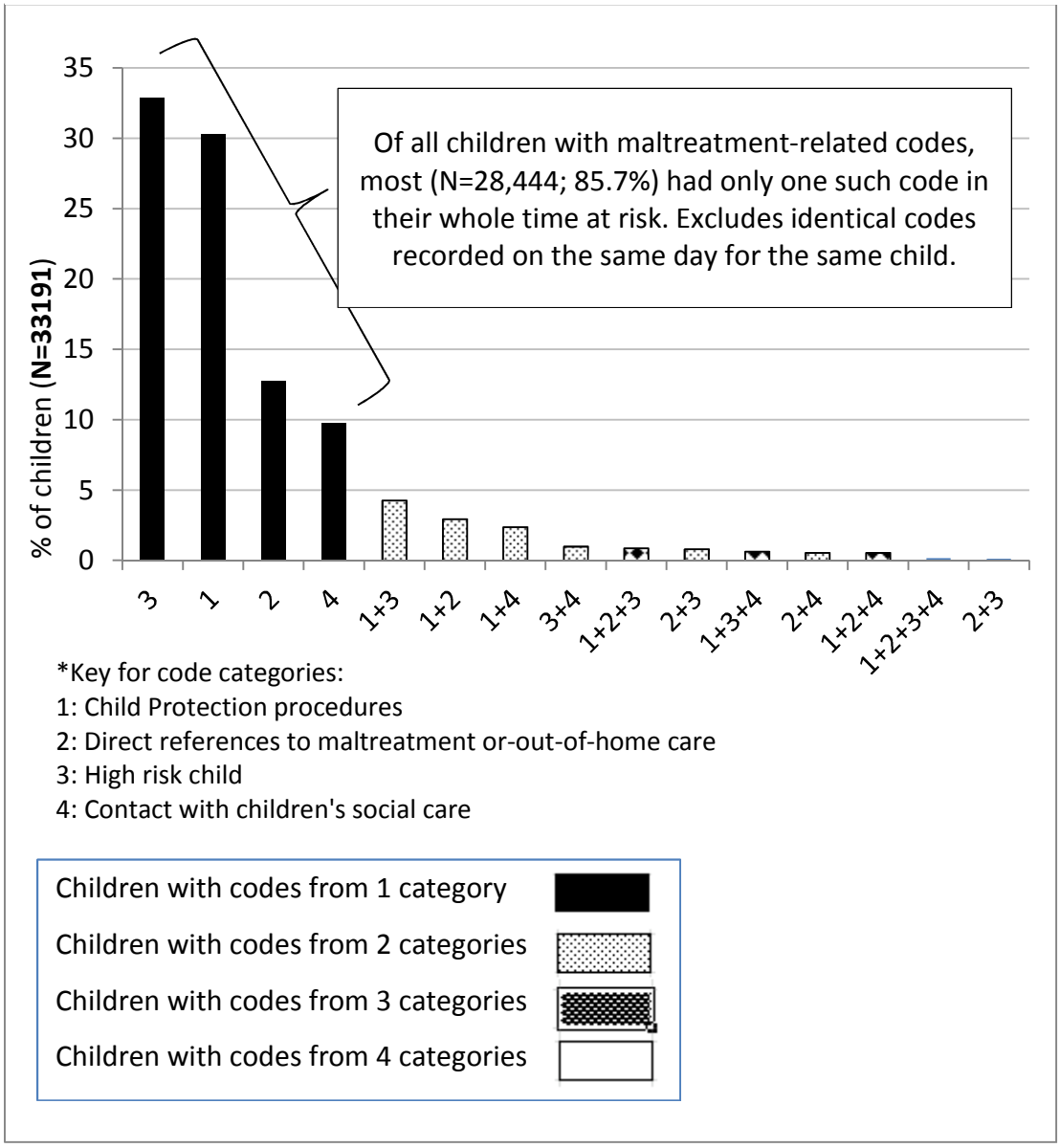
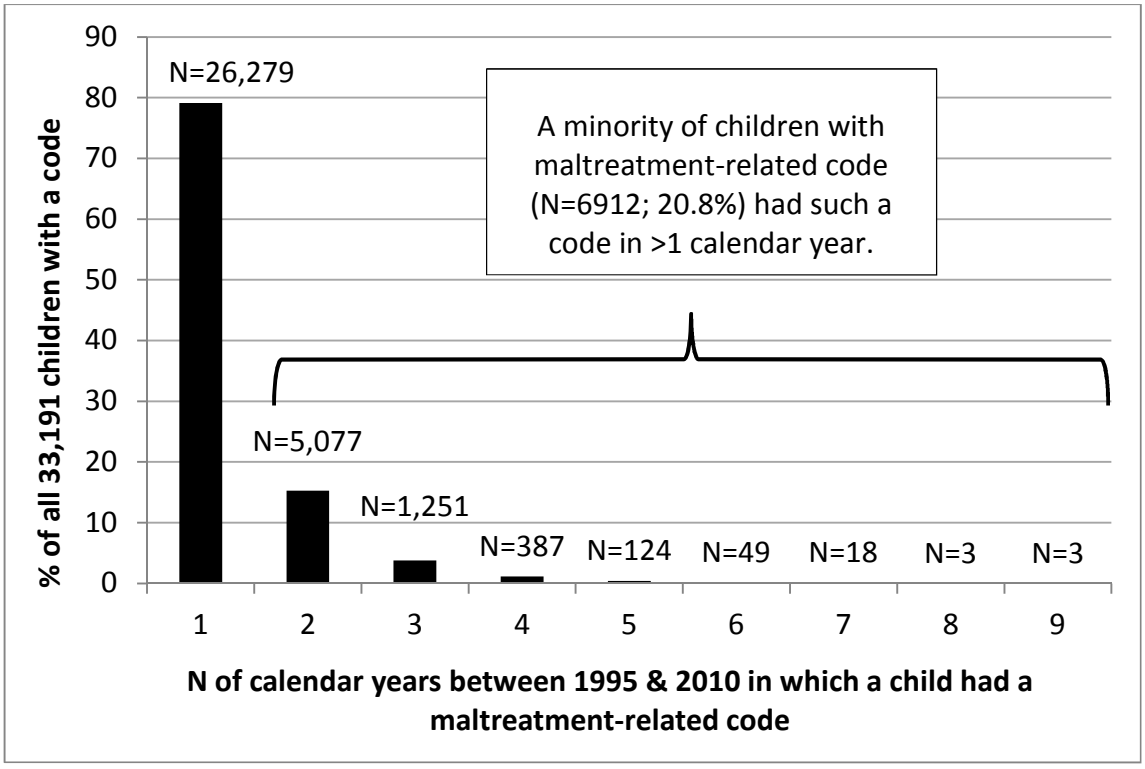


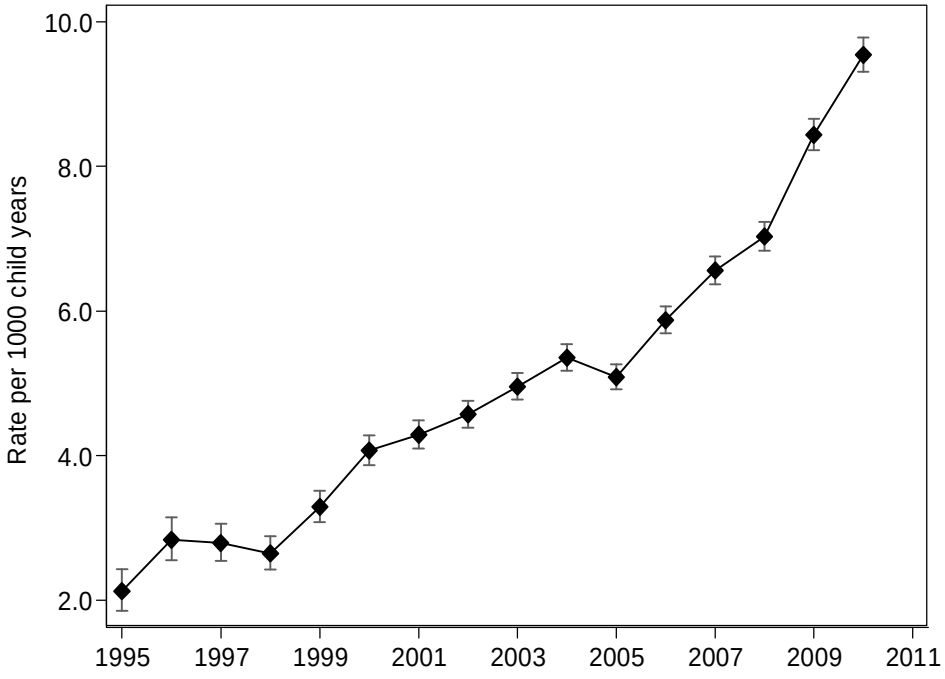
Figure 4-2: Distribution of children with maltreatment-related codes in ≥1 calendar year.



4.6.2 Variation over time 1995-2010

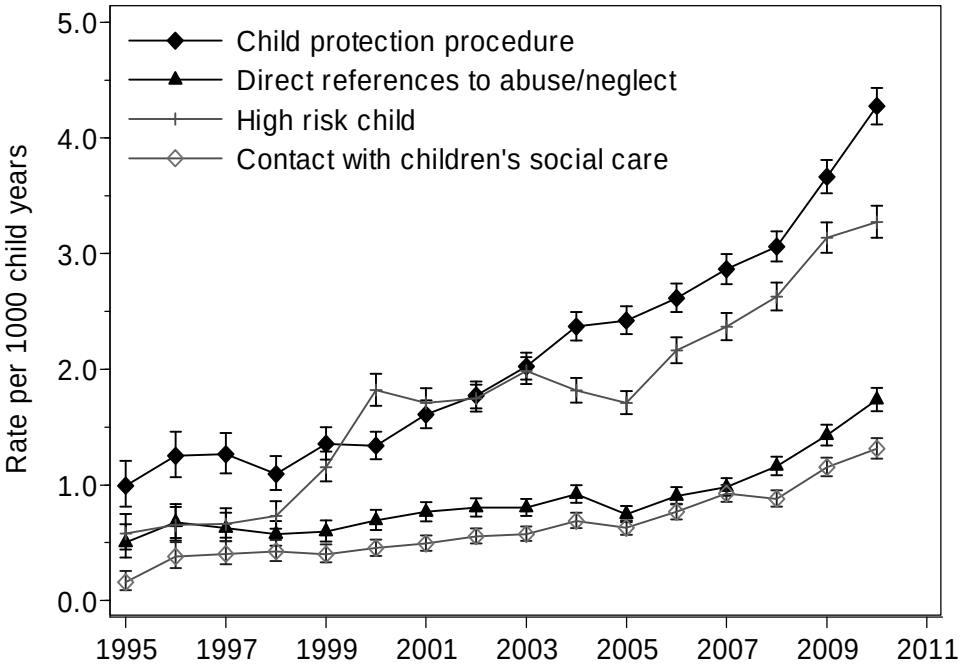
Between 1995 and 2010 there was a year on year increase of 10.8% (95% CI 10.5, 11.2) in the rate of any maltreatment-related codes between 1995 and 2010 (see Figure 4-3 and Table 4-2). There was an upward trend across all subcategories of codes, age groups, deprivation quintiles and sex. The shape of the increase was best described as log linear (rather than a linear trend or a linear trend with a change point in 2005, see section 4.5.7, p. 146 for more information about how a log linear model was determined to be the best fit).

Figure 4-3: Incidence of any maltreatment-related code 1995-2010



*First event per child per calendar year included in denominator

Figure 4-4: Incidence of maltreatment-related codes 1995-2010, by subcategory of code



*Children with an event each year / all children registered in that year

As Figure 4-4 and Table 4-2 show the annual rate of increase was similar in the four subcategories compared to any maltreatment-related code, except for codes making direct references to maltreatment or out-of-home-care, where the increase was less. The increase was steepest for children under five years old. As shown in Table 4-2, there was no difference in the rate of change across deprivation quintiles or sex, except high risk child codes where the rate of increase was steeper amongst boys compared with girls. The interaction between age group and deprivation quintile showed a steeper year on year increase for deprived children in the mid age ranges (1-4 years and 5-10 years) than for deprived children at the extremes of age (see Appendix 4.6 for graphics displaying this interaction)).

Table 4-2: Average annual percentage change per calendar year 1995-2010 by subcategory of maltreatment-related code and child characteristics.

% change per calendar year 1995-2010 (95%CI)					
	Any maltreatment-related code	Child protection procedure	Direct reference to maltreatment or out-of-home-care	High risk child	Contact with children's social care
Overall *	10.8 (10.5, 11.2)	11.6 (11.1, 12.1)	7.5 (6.8, 8.3)	11.8 (11.2, 12.4)	11.2 (10.2, 12.1)
Boys†	11.5 (10.8, 12.2)	11.5 (10.8, 12.2)	8.2 (7.1, 9.2)	14.3 (13.4, 15.3)	10.4 (9.1, 11.7)
Girls†	10.2 (9.7, 10.7)	11.7 (10.9, 12.4)	6.7 (5.7, 7.8)	9.8 (8.9, 10.6)	11. 8 (10.5, 13.1)
<1y†	13.1 (12.1, 14.0)	11.2 (9.9, 12.5)	12.1 (10.0, 14.3)	16.1 (14.4, 17.8)	13.1 (12.1, 14.0)
1-4y†	12.8 (12.1, 13.5)	11.7 (10.8, 12.7)	9.2 (7.5, 10.8)	18.0 (16.7, 19.4)	12.8 (12.1, 13.5)
5-9y†	11.4 (10.7, 12.2)	12.0 (11.0, 13.0)	6.7 (5.2, 8.3)	14.3 (12.9, 15.8)	11.4 (10.7, 12.2)
10-15y†	8.7 (8.0, 9.3)	10.7 (9.7, 11.8)	4.2 (2.9, 5.5)	7.9 (6.7, 9.1)	8.7 (8.0, 9.3)
16-17y†	4.8 (3.7, 5.9)	11.2 (8.3, 14.1)	8.8 (5.8, 11.8)	1.2 (0.0, 2.6)	4.8 (3.7, 5.9)
1at (least deprived)†	10.7 (9.6, 11.7)	12.7 (10.7, 14.6)	8.22 (6.2, 10.3)	10.9 (9.2, 12.7)	11.7 (8.9, 1.45)
2nd†	10.4 (9.4, 11.5)	11.5 (9.7, 13.4)	4.6 (2.6, 6.7)	11.7 (10.0, 13.5)	9.6 (6.9, 12.4)
3rd†	11.0 (10.2, 11.8)	11.7 (10.5, 13.0)	8.3 (6.5, 10.1)	11.6 (10.2, 13.1)	12.4 (10.3, 14.5)
4th†	10.9 (10.2, 11.6)	11.9 (10.9, 12.8)	6.9 (5.4, 8.5)	11.3 (10.1, 12.5)	10.6 (8.8, 12.4)
5th (most deprived)†	11.0 (10.4, 11.7)	11.6 (10.7, 12.5)	8.5 (7.0, 10.0)	12.3 (11.1, 13.6)	11.1 (9.4, 12.9)
Missing deprivation†	9.8 (7.3, 12.3)	4.3 (1.0, 7.7)	8.4 (2.7, 14.3)	11.5 (7.1. 16.1)	12.5 (6.6, 18.6)
* Adjusted for all variables in table and over-dispersion at the practice level.					
† Adjusted for all other variables in table and over-dispersion at the practice level.					

4.6.3 Rates and rate ratios in 2010

In 2010 the annual incidence of children with any maltreatment-related code was 9.5 (95%CI 9.3, 9.8) per 1000 child years, equivalent to a code entered in the record of 0.8% (95%CI 0.8, 0.8) of all children registered in 2010. The incidence was highest for child protection procedures (4.3 per 1000 child years (95%CI 4.1, 4.4)) and lowest for contact with children's social care (1.3 per 1000 child years (95%CI 1.2, 1.4;)). This is equivalent to a new code for 0.4% (95% CI 0.4, 0.4) and 0.1% (95%CI 0.1, 0.1) of all children registered in 2010, respectively. The incidence of children with codes for child protection plans (excluding other child protection procedures) was 2.3 per 1000 child years at risk in 2010 (95%CI 2.2, 2.4), equivalent to a new code for 0.2% of all children registered in that year (95%CI 0.2, 0.2). See Table 4-3 for full details of incidence rates in 2010 and Appendix 4.7 for prevalence rates in 2010.

Table 4-3: Incidence rate and rate ratios for maltreatment-related codes in 2010, by code subcategory and child characteristics.

	Any maltreatment-related		Child protection procedures		Direct references to		High risk child		Contact with Children's Social	
	Rate*	Rate ratio**	Rate*	Rate ratio**	Rate*	Rate ratio**	Rate*	Rate ratio**	Rate*	Rate ratio**
All children	9.5 (9.3, 9.8)	—	4.3 (4.1, 4.4)	—	1.7 (1.6, 1.8)	—	3.3 (3.1, 3.4)	—	1.3 (1.2, 1.4)	—
Boy	9.2 (8.9, 9.5)	baseline	4.2 (4.0, 4.5)	baseline	1.8 (1.6, 1.9)	baseline	3.0 (2.9, 3.2)	baseline	1.3 (1.2, 1.4)	baseline
Girl	9.9 (9.5, 10.2)	1.1 (1.0, 1.2)	4.3 (4.1, 4.6)	1.0 (0.9, 1.1)	1.7 (1.6, 1.9)	1.0 (0.9, 1.2)	3.5 (3.3, 3.8)	1.2 (1.1, 1.3)	1.3 (1.2, 1.5)	1.1 (0.9, 1.2)
<1y♠	24.9 (23.3, 26.6)	4.3 (3.8, 4.9)	10.8 (9.8, 11.9)	8.9 (7.0, 11.4)	4.7 (4.0, 5.4)	4.0 (3.0, 5.2)	9.6 (8.6, 10.6)	3.7 (3.0, 4.6)	2.4 (2.0, 3.0)	2.2 (1.6, 3.0)
1-4y	13.1 (12.6, 13.7)	2.4 (2.1, 2.7)	6.0 (5.6, 6.4)	5.0 (4.0, 6.3)	2.5 (2.3, 2.8)	1.9 (1.5, 2.5)	4.8 (4.5, 5.2)	2.1 (1.7, 2.5)	1.4 (1.2, 1.6)	1.3 (1.0, 1.8)
5-9y	8.4 (8.0, 8.9)	1.6 (1.5, 1.9)	4.2 (3.9, 4.6)	3.7 (3.0, 4.7)	1.3 (1.2, 1.5)	1.1 (0.9, 1.6)	2.7 (2.4, 2.9)	1.2 (1.0, 1.5)	1.2 (1.0, 1.4)	1.2 (0.9, 1.5)
10-15y	7.2 (6.8, 7.5)	1.4 (1.3, 1.6)	3.3 (3.1, 3.5)	2.9 (2.3, 3.7)	1.3 (1.2, 1.5)	1.2 (0.9, 1.6)	2.1 (1.9, 2.3)	0.9 (0.8, 1.1)	1.3 (1.1, 1.4)	1.3 (1.0, 1.6)
16-17y	5.1 (4.6, 5.6)	baseline	1.1 (0.9, 1.3)	baseline	1.1 (0.9, 1.3)	baseline	2.2 (1.9, 2.6)	baseline	1.0 (0.8, 1.2)	baseline
Least deprived†	4.0 (3.7, 4.3)	baseline	4.0 (3.7, 4.3)	baseline	1.5 (1.3, 1.6)	baseline	1.7 (1.5, 1.9)	baseline	0.7 (0.5, 0.8)	baseline
2	4.6 (4.2, 4.9)	1.2 (1.0, 1.4)	4.6 (4.2, 4.9)	1.0 (0.8, 1.26)	1.6 (1.4, 1.8)	1.3 (1.0, 1.7)	1.6 (1.4, 1.9)	1.1 (0.9, 1.4)	0.6 (0.5, 0.8)	0.8 (0.6, 1.1)
3	9.1 (8.6, 9.6)	2.2 (2.0, 2.4)	9.1 (8.6, 9.6)	2.4 (2.0, 2.8)	3.9 (3.5, 4.2)	2.1 (1.7, 2.7)	3.1 (2.8, 3.4)	2.0 (1.6, 2.4)	1.3 (1.1, 1.5)	1.6 (1.2, 2.1)
4	14.2 (13.5, 14.9)	3.0 (2.7, 3.4)	14.1 (13.5, 14.9)	3.9 (3.3, 4.6)	7.1 (6.6, 7.6)	2.2 (1.7, 2.9)	4.7 (4.3, 5.1)	2.7 (2.3, 3.2)	1.8 (1.6, 2.1)	2.1 (1.2, 2.1)
Most deprived	19.1 (18.2, 20.0)	4.5 (4.0, 5.1)	21.33 (20.38, 22.3)	5.6 (4.7, 6.6)	10.3 (9.6, 11.0)	3.9 (3.0, 5.0)	7.0 (6.4, 7.5)	4.0 (3.3, 4.8)	2.7 (2.4, 3.1)	2.7 (2.0, 3.5)
Missing	12.1 (10.5, 13.8)	2.4 (2.1, 2.9)	12.1 (10.5, 13.8)	2.4 (1.8, 3.1)	4.4 (3.5, 4.5)	2.5 (1.8, 3.7)	3.6 (2.8, 4.6)	1.8 (1.3, 2.4)	2.2 (1.6, 3.0)	2.6 (1.8, 3.8)

♠ Age at first maltreatment-related code in 2010

† Deprivation quintiles based on Townsend score

* Unadjusted

** Adjusted for other characteristics in table and overdispersion.

The incidence rate of any maltreatment-related code for infants in 2010 was 24.9 per 1000 child years (95%CI 23.3, 26.6). This was more than twice as high as for children aged 1-4 years and just over four times higher than for children in the oldest age group. The prevalence of any maltreatment-related code in the same year was 1.5% (95%CI 1.4, 1.6) for infants and 1.2% (95%CI 1.1, 1.2) for children aged 1-4 years (see Appendix 4.7 for prevalence rates for 2010). A comparison of the incidence rates and prevalence for the two youngest age groups suggests that very high incidence rate for infants was an artefact of the data. It is likely that delays in registering babies after birth leads to a shortened time at risk in the database for the youngest age group but that concerns identified in the pre/postnatal period before the child's registration are still recorded in the database. This would lead to a shortened time at risk but not a proportional reduction in the number of recorded concerns. For children aged under one year at the time of registration, the mean number of days between birth and registration was 58.7.

The most deprived children had an annual incidence rate of 19.1 per 1000 child years in 2010 (95%CI 18.2, 20.0), which was four and a half times higher than for the least deprived children. There was no difference between boys and girls.

4.6.4 Between-practice variation in THIN 2008-2010

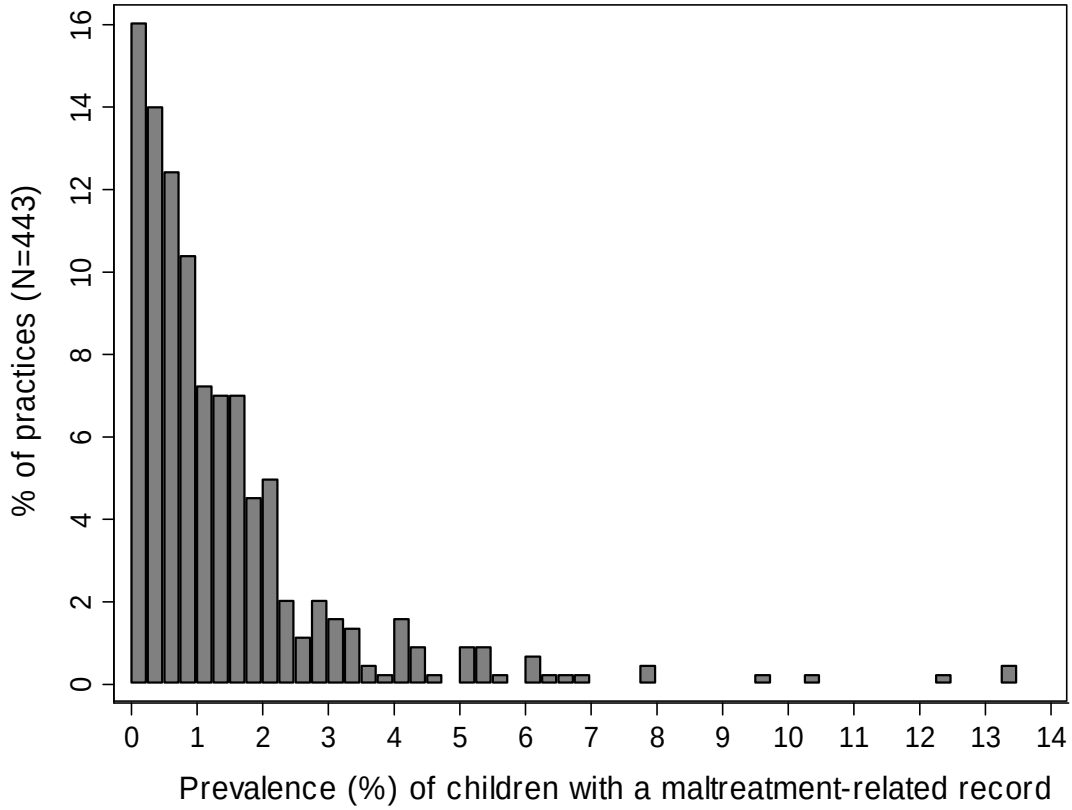
As shown in Table 4-4 and Figure 4-5, the unadjusted prevalence of children with any maltreatment-related code over three years (2008-2010), ranged from zero to 13.4% with a median of 0.9%. Of the 433 practices, 11 (2.5%) had no children with maltreatment-related codes in the three years but 23 (5.3%) practices had entered a relevant code for 4% or more of their registered children in the same period. One in three practices did not have any children with codes indicating contact with children's social care and one in five did not have any codes that made direct references to maltreatment or out-of-home care (see Table 4-4).

Table 4-4: Variation in the prevalence (%) of children with maltreatment-related records between 2008 and 2010 (raw data)

	Unadjusted prevalence (%) of children with a code					N of 'zero' practices♠
	Mean	Median	Min	Max	IQR*	
Any maltreatment-related record	1.46	0.9	0	13.42	1.4	11 (2.5%)
Child protection procedure	0.64	0.36	0	7.3	0.67	54 (12.2%)
Direct references to maltreatment/ out-of-home care	0.27	0.12	0	7.6	0.27	100 (22.6%)
High risk child	0.55	0.17	0	12.8	0.43	91 (20.5%)
Contact with children's social care	0.24	0.72	0	5.5	0.21	153 (34.5%)

* Interquartile range.
♠Number of practices with any children with relevant codes 2008-2010, of a total of 443 practices contributing data in this period.

Figure 4-5: Unadjusted variation in prevalence of children with any maltreatment-related code in practices contributing data between 2008 and 2010



Although there was between-practice variation in the crude prevalence of maltreatment-related concerns (0-13.4%, see Table 4-4), after adjusting for practice case-mix (sex, age and deprivation) there was no evidence of unexplained variation beyond that due to random variation: all case-mix adjusted practice estimates were within two standard errors of the grand mean. There was no evidence of any effect of over-dispersion on the results.

The analyses of between-practice variation were limited to children with any maltreatment-related code as I did not find any evidence of unexplained variation over and above random variation for this main outcome. It is almost certain that the findings would be the same for the secondary outcomes as the lower event rates in the secondary outcomes would have made it more difficult to identify variation over and above that which might be expected from chance alone.

4.6.5 Sensitivity analyses

Sensitivity analyses made no qualitative difference to the incidence rates in 2010. The biggest impact on incidence was seen when I excluded the first five months of time at risk for children who had registered before their first birthday. For this youngest age group, incidence rates decreased by approximately two per 1000 child years. However, these rates were still similar to the lower 95% CI of the main analyses. Excluding other UK countries from the analysis made no qualitative difference to the incidence rates for 2010 for any of the categories of maltreatment code: the rate of any maltreatment-related code for 2010 in the 336 English practices was 9.9 per 1000 child years (95% CI 9.7, 10.2). Full results for sensitivity analyses are shown in Appendix 4.8.

4.7 Discussion

4.7.1 Summary of findings

The use of maltreatment-related codes in children's primary care records has increased steeply since 1995 and is consistent across practices in the THIN sample once my measures of case-mix and random error have been taken into account. The increasing use of maltreatment-related codes over time was seen in all subcategories of maltreatment-related code and across all measured child socio-demographic characteristics.

4.7.2 Strengths and limitations

Due to the representative nature of the THIN database and its large coverage (6% of the UK population in 2010), the results are likely to be generalizable to UK primary care practices. It is possible that the INPS Vision computing software which is used by all practices contributing to THIN may be more conducive to coding than other software, specifically TPP Systm One.[4] If this were the case, it may mean that the incidence of coded concerns in my study would be higher than amongst the general GP population. However, there was no evidence of any difference in incidence rates between coding systems (including INPS Vision and TPP Systm One) in the analyses I conducted with the 11 practices during the development phase of the study (see Chapter 3, Table 3-5, p. 130 for results from these 11 practices), although small numbers of practices using each software might have prevented us detecting true differences.[1]

THIN captures data that are recorded for clinical purposes often during or shortly after a consultation between a patient and a GP. The information that gets coded and the codes that are used has much to do with individual GP preference and value judgements about what is important, helpful and acceptable to put in the primary care record.[178] Coding is also influenced by practice-level policies such as

[4] *This was raised as feedback from a group of expert GPs following presentation of results in this chapter at the Primary Care Safeguarding Forum, 22nd September 2012.

the use of templates (structured forms to enter data) and self-perpetuating ballistic coding (computer software that prioritises the most frequently used codes in drop down lists). Finally, coding is influenced by wider policy that incentivises GPs to code certain conditions, usually via pay for performance systems. This means that coding in THIN is not comprehensive and is unlikely to reflect accurately all activity that is happening in primary care, an idea which was supported by the results of the development phase reported in Chapter 3.THIN can provide data on the frequency with which maltreatment-related concerns are coded in the electronic record but cannot tell us about concerns that are recognised and/or acted upon but not recorded. Similarly, THIN cannot be used to provide accurate data about rates of maltreatment among children presenting to GPs, some of whom will never have their problem recognised, or rates among children in the wider community, some of whom will never present to GPs at all. The conclusions we can draw from THIN must be limited to those relating to the *coding* of maltreatment-related concerns and, by implication, *minimum* estimates of relevant problems known to GPs.

4.7.3 Comparison of absolute rates with other data

As shown in Table 4-5, there are very large discrepancies between estimates of the burden of maltreatment in the community and the rate of maltreatment-related codes in THIN. Based on the literature review that I report in my introductory chapter, we can assume that maltreated children present to primary care services with about the same frequency as similar but non-maltreated children (see Chapter 1, 1.5.2.1, p. 57 for the results of the literature review which generated this assumption). This means the estimates based on maltreatment-related codes in the child's record only represent the tip of the ice-berg in terms of the scale of maltreatment-related problems presenting to GPs.

As Table 4-5 shows, the discrepancy between what was coded in THIN and community estimates was lowest for child protection plans and highest for "high risk child" and referrals to children's social care. This may be because GPs are more reluctant to code concerns that are below the threshold for children's social care ("high risk" children) and more likely to receive information about child protection

procedures than referrals to children's social care made by schools, the police or other healthcare professionals. This is extremely likely given that English statutory guidance recommends that GPs be informed of all children who are made the subject of a child protection plan.[6] One qualitative study reported poor information flow from children's social care even following a child protection referral but the study did not contain any views as to whether this happened differentially for differing levels of concern.[61]

Table 4-5: Comparison of results from THIN with other data

Measure	Children with a code in THIN	Comparison with other data	
	Prevalence % (95%CI)	Prevalence %	Details
Maltreatment	0.8 (0.8, 0.8)	4-10	Population-based surveys of parents and/or children (self-report).[17 18 34]
Child protection plan*	0.2 (0.2, 0.2)	0.4	Children who were made the subject of a child protection plan in England 2010-11.[202]
High risk child	0.3 (0.3, 0.3)	2-27	According to a study of 12, 583 children and parent dyads from a UK birth cohort study, in 2000-2001, 27% of children in England experienced two or more hardships.•[152] According to a cross-sectional survey of a representative sample of 7,657 families, in 2005, 2% of families experienced five or more indicated of disadvantage. •[28 153]
Contact with children's social care	0.1 (0.1, 0.1)	5.6	Children referred to children's social care for any reason in England 2010-11.[202]

*Excluding other child protection procedures. The discrepancy between the % of children with a child protection plan code in THIN in 2010 and the % of all children who were made the subject of a child protection plan in England in 2009-10 was consistent across all age groups.

•See Chapter 1, Figure 1-2, p. 79 for explanation of measures used in these studies.

A further discrepancy between my study and studies based on community samples is that in my sample younger children had higher rates of maltreatment-related codes than older children. In community samples there are higher rates of maltreatment among older children.[17 18] As explained in my introductory chapter (Chapter 1, 1.3, p. 39) although there may be some differences in the likelihood of disclosing maltreatment between parents (who report for young children) and older children (who report for themselves), this is unlikely to fully explain the increase of maltreatment with age.[35] The focus on young children in THIN may be explained by increased GP awareness of maltreatment in younger children, by information from health visitors (who only work with preschool children), or by a lower consultation rate for older children with fewer opportunities for identification and recording.[97 203]

The results of my development phase (Chapter 3) suggested that using my measure of maltreatment-related codes would underestimate all maltreatment-related concerns known to general practice. With this is mind and amidst claims that GPs are disengaged from child safeguarding (as described in Chapter 1, section 1.5.4, p.61) rates of coded concerns are surprisingly high in comparison to the coded incidence of other common childhood conditions. For example, the annual incidence of maltreatment-related codes in children's records in 2010 (9.5 per 1000 years of registration) was only a third lower than new diagnoses of asthma in the records of children aged less than five during 2005 (14.3 per 1000 years of registration).[204] Unlike codes relating to asthma diagnoses,[204] we found maltreatment-related codes to be increasing year on year. Given the complex and often chronic nature of maltreatment-related problems, we can hypothesise that responding to these problems might represent a significant burden to general practitioners which might be comparable to the burden of work associated with diagnosing and managing other common childhood conditions.

4.7.4 Between practice-variation

As explained in my introductory chapter, there has been polemic debate among GPs as to whether and how far GPs should or are able to be involved with child protection (Chapter 1, section 1.5, p. 56).[122 124 127 205] In light of this controversy, it was surprising that there was such consistency across practices in the THIN data, once case-mix and random error were taken into account. The annual incidence rates were not driven by a few 'expert' practices. However, small numbers of children with codes in each practice limited the power to detect moderate variation between practices.

4.7.5 Explanations for the increase over time

Increasing rates of maltreatment-related codes are not explained by rising background rates of child maltreatment or related events. UK data suggest that maltreatment in the community[18 206] and referrals to children's social care[202 207] have been stable in recent years. There have been increases in the rate of child protection plans in the community, especially for infants, but this does not explain the rise in all four subcategories of maltreatment-related concerns and across all age groups.[202 207]

It is unlikely that such a steady increase as seen in my results is explained by a response to a single event such as high profile child death or a single policy.

There was no evidence of diagnostic transfer between codes; all four of my subcategories increased at a broadly similar rate. This is in contrast to other studies measuring maltreatment-related concerns in hospital admission[183] and depression in primary care[180] which have found an increase in indirect, euphemistic or "symptom" codes for these conditions and a proportional decrease in diagnostic codes. Unlike my study, in these studies the overall incidence rate remained stable over time.

Increases may reflect system changes, such as administrators systematically coding children's social care correspondence and reports. However, codes reflecting

judgements (e.g. “high risk child” codes) increased at a similar rate to those reflecting children’s social care child protection procedures.

It seems most likely that the increasing rate of maltreatment-related codes in UK primary care is due to changes in coding behaviour and/or increased recognition by GPs. Studies have shown that Quality Outcomes Framework (QOF; pay for performance) has increased coding for a range of diseases in adults, including diseases for which coding is not incentivised under the scheme.[199] Although I found no evidence that the model with a change point in 2005 (the first full year after QOF) was a better fit for the trend over time than the log linear model, I cannot rule out the contribution of QOF to the increase in maltreatment-related codes. My results suggest that there was a gradual change in attitudes to recording maltreatment-related concerns and attendant recording behaviour rather than a step-change due to one specific policy.

4.8 Key points from Chapter 4

- I undertook analyses of a large and representative UK primary care database (THIN) and included data from 1995-2010 from 448 practices. I used the measure of maltreatment-related codes which I developed in an early phase of the PhD study (reported in Chapter 3).

- Given views of GPs as disengaged from child safeguarding and barriers to coding maltreatment-related concerns, in 2010 there was a surprisingly high proportion of children had a maltreatment-related code entered in their electronic primary care record (0.8%). These rates did not appear to be driven by a few ‘keen’ or ‘expert’ practices.

- Rates of maltreatment-related codes had increased in a linear fashion since 1995 at an average of 10% per year and increases were seen across all categories of maltreatment-related codes and all measured child characteristics. Despite the increases, there is substantial scope for improvement in recording.

- Estimates of maltreatment-related codes function as a minimum estimate of maltreatment-related concerns in general practice; they underestimate the proportion of all children who have maltreatment-related problems known to general practice.

5 CHAPTER 5: Methods for qualitative interviews and observations

Statement of authorship

I carried out all the work described in this chapter.

5.1 Content and structure of chapter 5

This chapter contains the background, aim, objectives and methods for the qualitative data collection and analysis (phase 3). The results and discussion for phase 3 can be found in Chapter 6, starting on p. 202).

5.2 Background

From the analyses of the THIN database (reported in Chapter 4, starting on p.140), we know that recording of child maltreatment-related concerns *can* be done in general practice settings and is being done increasingly, if sub-optimally, across the UK. However, these epidemiological analyses do not tell us what other responses to child maltreatment are occurring in general practice alongside or instead of recording.

Identifying and understanding other possible responses to maltreatment-related concerns can be obtained by in-depth qualitative research with GPs and their primary care colleagues. I conducted this type of research in the qualitative phase of my PhD (phase 3), which I present in this and the following chapter.

5.3 Objectives

1. To generate hypotheses about what constitutes a maltreatment-related concern for GPs.
2. To generate a rich description of the types of responses that a small sample of GPs used in responding to maltreatment-related concerns.

Because my study is based on data from a small and select sample of practitioners, this study can only generate hypotheses about what might feasibly done in primary care. It does not aim to describe routine practice across the country. Evaluating the effectiveness and safety of the responses that I identified was beyond the scope of my PhD study. For this reason, I did not aim to draw conclusions about what GPs *should* be doing in response to maltreatment-related concerns.

My objectives were to describe and understand some possible responses to maltreatment-related concerns in general practice.

5.4 Methods

5.4.1 A note on the refined scope of the qualitative study (phase 3).

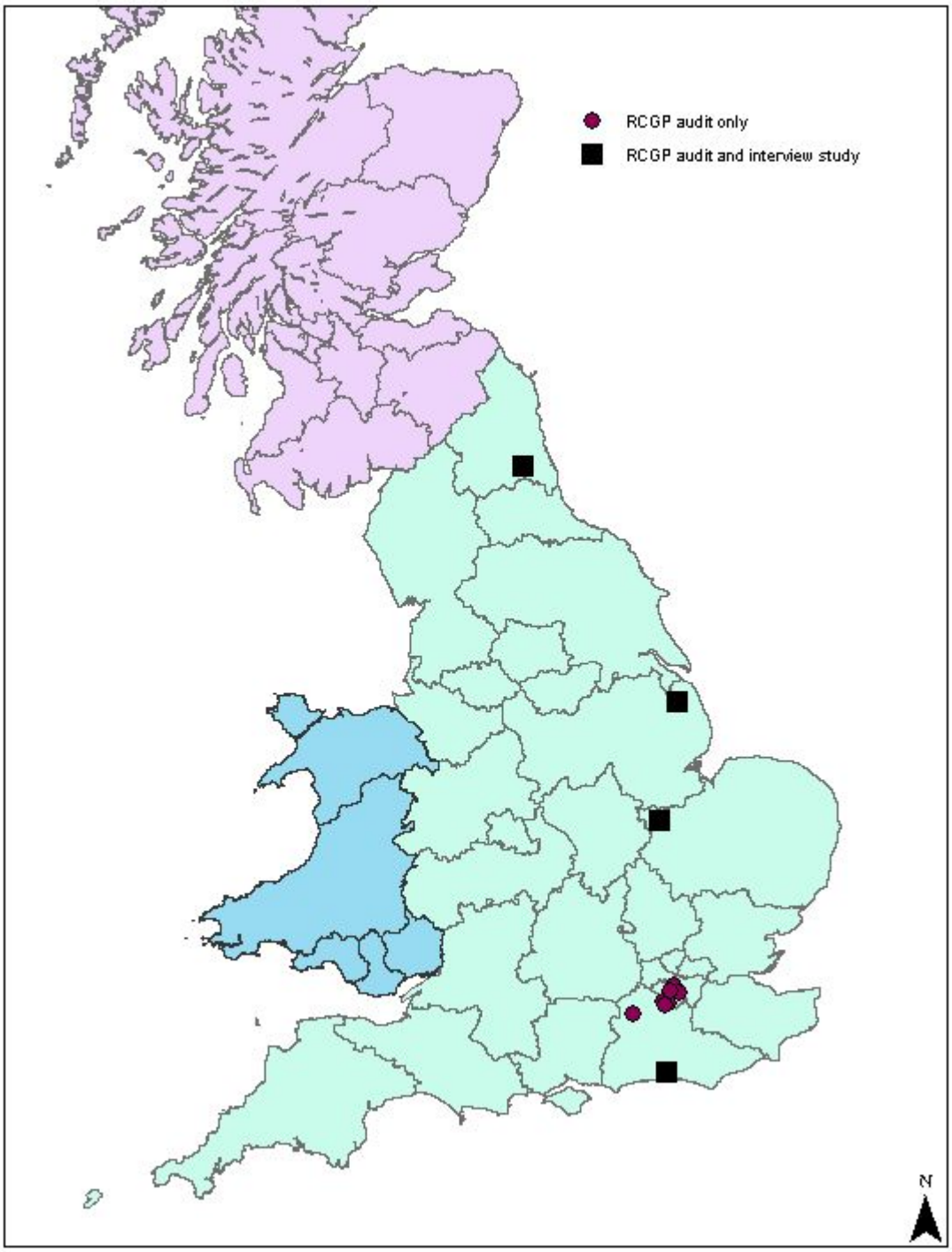
Initially the scope of the study included responses to child maltreatment by the whole primary care team: GPs, practice nurses and health visitors. However, it soon became clear that this was an unfeasibly wide scope to cover with available resources and, towards the end of data collection, I refined the aim to focus on GP responses. In keeping with my initial aim, I recruited GPs, health visitors and practice nurses. Most of the analyses reported in this chapter focus on data from GP interviews with some sub-sections of the results also including data from health visitors and practice nurses. I describe the relative contributions of GP, health visitor and practice nurse interviews at the beginning of each results section in Chapter 6..

I conducted in-depth one-on-one interviews with GPs, health visitors and practice nurses at four GP practices in England and observed a team meeting at each site in which professionals discussed families identified as vulnerable.

5.4.2 Data collection sites

The data collection sites were chosen from the same convenience sample of 11 sites that participated in the RCGP multisite safeguarding audit (for a description of these 11 sites see Chapter 3, Table 3-2, p. 111). From the 11 potential sites in the sampling framework, I purposively selected four as "best practice" sites. These were the sites where the lead GP at the practice was a child protection "expert", defined as those: who held a RCGP post connected to child protection, were a named child protection doctor, or who were involved in child protection policy or in delivering child protection training. In addition, I only sampled sites where there were regular team meetings to discuss vulnerable families (a proxy marker for good child protection practice)[87] as I planned to observe one of these meetings in the practices. Figure 5-1 shows the location of the four sites, which were chosen to give geographical spread and avoid being 'London-centric'. Only three practices participating in the RCGP audit had health visitors based in the practice and two of these were included as data collection sites. Potential differences between these two sites with and without on-site health visitors were kept in mind during the analysis and interpretation stages.

Figure 5-1: Map of United Kingdom showing practices participating in the RCGP audit and those that were selected as qualitative data collection sites



5.4.3 Sampling of participants

I took a pragmatic approach to sampling participants for interview and recruited in two ways. First, I asked the lead GP to act as a gatekeeper and introduce the study to colleagues, to hand-out information sheets (reproduced in Appendix 5.1) and, with consent, to give me the emails of potentially interested colleagues. See Chapter 3, section 3.6.1.1, p.132 for more information about how I developed the gatekeeper-researcher relationship. Secondly, I introduced the study to GPs, health visitors and practice nurses when I went to observe the vulnerable families meeting at each practice. I handed out more information sheets and asked participants to write their contact details on a sheet if they thought they may be able to participate. In total, I received the contact details for 21 professionals via these methods. I attempted to arrange an interview with all 21 professionals and although all initially agreed, four later declined due to time pressures (N=3) and a perceived need to contact the PCT to gain permission to participate (N=1). Three of the four professionals who agreed and later declined were health visitors and one a GP.

5.4.4 Designing and piloting the interviews

I chose in-depth interviews as the data collection method most likely to achieve my aims of understanding the complex experiences and practices of professionals working with families who prompt maltreatment-related concerns.

There were two important elements to the design of the interviews. First, I chose one-off unstructured *individual* interviews. Secondly, I sought to directly access each participant's *personal experience* in the interviews by asking them to tell me about specific children, young people or families about whom there had been maltreatment-related concerns and with whom they had been directly involved. My choice of one-off individual interviews and eliciting of personal narratives was based on two arguments put forward by experienced qualitative researchers alongside some practical considerations.

Using individual interviews, with sufficient trust and rapport, might be as close as researchers can get to "private" accounts of experiences, attitudes and beliefs.[159 188 208] In his work on parenting children with disability, Patrick West defines "private" accounts as those which tend to contain more deviant or controversial views and be based on real experiences, with all their complexity and difficulty and "public" accounts as tending to confirm the dominant ideology with talk of the 'generalised other'.[209] Per se, neither type of account is more valid than the other. However, seeking private accounts was more suited to my aim of understanding what *happened* in primary care, in all its messy difficulty. Conducting repeat individual interviews with participants might have further maximised my chances of eliciting private accounts[159] but was not practical given other demands on a GP's time. Individual interviews avoided the practical barriers of bringing together busy clinicians in one place at the same time as for focus groups or group interviews.

The work by Jocelyn Cornwell into health beliefs of people in East London (1984) is cited in support of using stories based on experience as a way of eliciting accounts that move beyond the socially acceptable or familiar.[**159**] For this reason I based my interviews around personal stories rather than asking questions in the abstract.

Additionally, this case-based approach had already been shown to successfully elicit rich data about child safeguarding in focus groups with GPs in Denmark, where the authors noted that:

> "GPs often conveyed their experiences and attitudes through anecdotes or detailed case stories from their own practice." [210 (p.3)]

Finally, based on the development phase, the "story" design of the interviews seemed feasible and acceptable to GPs (see Chapter 3, section 3.6.3.3, p. 134).

I conducted two pilot interviews in November 2011 with local GPs who were identified via my professional network. After the pilot participants had agreed to be interviewed, I emailed asking them to have in mind two or three children, young people or families who had prompted concerns about maltreatment and with whom they had been directly involved. This was all the guidance I gave but I made it clear that part of my interest was in hearing about why they had chosen particular cases. I began each interview by simply asking participants to pick one of the children (or young people or families) that they had in mind and to tell me a bit about the concern and why they had selected them for discussion. Once we had exhausted the first narrative, I asked the same question of the second case. I had four broad topics which I aimed to cover in the interview:

- The nature and types of concerns.
- Recording of the concerns and professional roles.
- Decisions and actions taken, outcomes hoped for and the perceived mechanisms by which these outcomes might be achieved.
- Perceived ways in which primary health care services could impact on outcomes for children with possible maltreatment.

These topics were outlined in my interview schedule (reproduced in Appendix 5.2). This interview design worked well for both pilot interviews and the participants were

able to talk in-depth about their experiences for a full hour. I took this same approach for all my interview data collection.

5.4.5 Interview participants

Table 5-1 gives details of the 17 participants whom I interviewed between November 2010 and September 2011. The sample consisted of 14 GPs (including one GP registrar), two practice nurses (including one nurse practitioner) and two health visitors. The participants tended to be experienced health professionals and to have worked for an extended period with their current team: almost two thirds (N=11) reported being qualified for 20 years or more (range 1-40y) and 58% (N=10) had worked in their current team for at least 10 years (range 6m to 2y.) Eight of the interviewees (47.1%) were "experts", defined as professionals who held RCGP posts connected to child protection, were named doctors, delivered child protection training, contributed to policy in the area or considered themselves to have specialist interest in child protection. Just over half the respondents were female (N=10/17; 60%). To protect the participants' identity, I have not identified the site at which each participant worked, either in Table 5-1 or anywhere else in the thesis. There were five participants each from Practices 1 and 2, four from Practice 3 and three from Practice 4. The two health visitors worked in different sites from each other, as did the two practice nurses.

Table 5-1: Characteristics of interviews and interview participants

Participant numbers and interview dates have been omitted from the table in order to protect participant identity. Participants are not listed in the order in which they were interviewed.

Interview Length (mins)	F/M	Job	Years with current team	Years qualified	CP?*
61	M	GP	16	25	Y
41	F	GP	0.7	5	N
63	M	GP	17	26	Y
29	M	GP	7	8	N
61	F	GP	20	30	N
46	M	GP	10	15	Y
27	M	GP	7	8	N
57	F	GP	23	27	Y
45	M	GP	18	23	Y
61	F	Nurse	12	32	Y
24	F	GP	17	20	N
59	F	HV	1	1	N
52	F	GP	0.5	40	Y
56	M	GP	12	31	N
40	F	GP Reg†	1	5	N
57	F	Nurse Prac†	13	20	N
58	F	HV	1.5	25	Y

*CP =Specialist expertise in child protection. Participants were asked about any qualifications, experience or expertise relevant to child protection and whether they had any specialist interest or expertise in child protection.
† Nurse practitioner = nurse with advanced education and clinical training within a specialty area who can undertake some of the same duties as doctors (e.g. prescribing). GP registrar =(junior) doctors undertaking vocational GP training.

5.4.6 Conducting the interviews

On the whole, the participants covered all my topics of interest during their free ranging narratives, without much prompting or guiding from me. This meant that, in practice, the interviews were unstructured. The exception to this was recording of concerns. Often this was not brought up and I made an effort to delay any question about recording until the end of the narrative and, when analysing, to note that I raised the subject rather than the participant. I took an interview schedule into each interview with me but stopped consulting it after the first few interviews

I recorded the interviews using a dictaphone and I made notes on each interview (impressions, major themes, things that surprised me, tone of the interview) shortly afterwards and always within 3 hours of the interview.

The interviews tended to occur directly after morning surgery or clinics and were often started late, due to overrun. The interviews were informal, with both myself and the participant usually drinking tea and the participant often eating lunch. Seven of the 17 interviews were interrupted, often more than once: five by colleagues seeking advice about a patient, three by telephones calls from patients or reception and one by building works.

The average length of the interviews was 50 minutes and as Table 5-1 shows, they ranged from 27 to 63 minutes. The interviews took place in a consulting room (N=13/17) or a meeting room (N=4/17) at the practice in which the participant worked. The participant chose the space in which we had the interview and this was usually made on a pragmatic basis (wherever was free and quiet at the time). In all but one interview that occurred in the consulting rooms, the participants sat in the doctor's chair in front of the computer and I sat in the patient's chair.

5.4.7 Reflexivity: my role in co-producing the interview data

> "Both researchers and researched are part of the world, and there is no privileged place we can occupy from which to study that world objectively".[159] (p.23)

My position as a researcher is that rigorous research provides information that is related to events happening in the world but also considers the political and socially constructed nature of those events. This is a constructivist stance,[211] sometimes described as "Hermeneutic realism".[188] From this point of view, qualitative research is necessarily co-produced: what is said and how it is said results from complex interplay between the researcher, the participant and the wider context of the exchange. A critical look at the context of the data production and the probable influence on the data is known as "reflexivity". A reflexive awareness facilitates judgement of findings in the context in which they were produced for the reader and encourages rigorous analysis.[159]

Since beginning my PhD, I have participated in policy discussions and forums about the role of health and children's social care professionals for children and young people who are in need of protection. I have read English policy documents, training guides and position statements from the RCGP on the subject and qualitative and quantitative research on child maltreatment in primary care settings. I also worked closely with a group of GPs during the development of recommendations for recording concerns in the child's health records (reported in Chapter 3). During this reading, thinking and exposure to "keen" GPs, I had arrived at a set of assumptions and beliefs that were likely to impact on the way I conducted interviews and analysed data. I wrote down the following assumptions in my research journal prior to embarking on interviews or observations:

- GPs have the potential for an important role in the management of children who give rise to concerns about child abuse or neglect.
- Views about the GP's role and current child protection practice will vary enormously between GPs and between practices.
- The areas where GPs might be able to help the most is with children, young people or families that are not currently also working with children's social care.

- GPs are (theoretically) competent to assess risk in these children and provide therapeutic support to families who are not meeting children's social care child protection thresholds.
- GPs are likely to manage whole families, the members of whom present with their own multiple social and medical problems.
- It is important that concerns get recorded in some form that can be accessed by others in the practice and that these concerns are discussed.

From working closely with expert and keen GPs, I developed a respect for GPs and the difficulties of the task of protecting children in this role which made me feel sympathetic towards them.

Now, looking at back at what I have written over a year ago, I see that I did not sufficiently unpick or challenge myself. Did I mean families that were not working with children's social care at all or did I mean families that were not receiving child protection services from children's social care (assumption 3 above)? It is now impossible for me to remember my thinking then, unclouded by my thinking now. If I were to do this again, I would ask my qualitative supervisor to look at what I had written and challenge me to be clearer or more precise about my assumptions. I would also go through my first transcripts alongside my written assumptions and see how I had or had not brought them to the interview.

During the interviews I made a conscious effort to set aside my assumptions, vague as they were, and to prompt and probe equally on views that I did and did not expect or share. To create rapport and a comfortable environment, I tried to show understanding of the participant's position rather than agreement or disagreement with the position. For example, I would encourage speaking by verbal cues such as. "hmmm" and "I see" and when it was my turn to speak, I would sometimes summarise what I had understood them to say. When analysing the first few interviews I noticed that a disadvantage of my approach was that I did not challenge the participants when, for example, a participant seemed to express two incompatible views within an

interview. On one hand, it is acknowledged that challenging contradictory beliefs or probing meanings can undermine rapport, make the respondent feel threatened or uncomfortable and threaten the quality of data. [159] [188] However, at the other extreme, I realised that my desire to create rapport had led me to be uncritical in exactly the way that experienced qualitative researchers such as Kathy Charmaz advises against:

> "Rather than uttering "uh huh" or just nodding as if meanings are shared, an interviewer may say: "That's interesting, tell me more about it"."[212]

In later interviews I became more proficient at negotiating a path between rapport and challenge, although when analysing the data, I still found missed opportunities for probing and challenge. Many of the opportunities were only visible in retrospect, once data analysis was nearing the end. For example, it was only after the interviews were completed that I realised the importance of one specific type of family, who were only ever briefly mentioned by participants, as a deviant case that would help to define and understand the other types of families with whom the participants described being far more active and engaged.[*] This meant that I allowed participants to move swiftly on from these families and missed opportunities for probing and challenging relevant concepts. In contrast, by my third interview, my preliminary analyses had alerted me to the importance of neglect in the stories and I probed and asked about this in subsequent interviews, enriching my data on this theme. If I were to do the study again, I would be stricter with myself about spending more time analysing the interview data as I went along.

I felt that participants were candid and open with me during the interviews and did not just give me the official view or party line (i.e. I did not elicit "public" accounts). I heard about professional uncertainty, doubt, emotional involvement and mistakes. On reflection, there were a combination of factors that contributed to this feeling of candour in the interviews. First, I was genuinely interested to hear the views and

[*] I came to classify these particular deviant cases as 'straightforward' families. These and the other types of families are described in detail in the results section (Chapter 6, section XXX).

experiences of the participants and found what they were saying powerful and important. This and my sympathetic view of GPs will have come across in my interviewing manner and may have contributed to the rich data I collected. Secondly, I am not a professional (doctor, teacher, social worker, police officer) and am junior in status and age, compared to the practitioners I was interviewing. A study into the implications of using peer interviewers (i.e. doctors interviewing doctors) suggested that interviewees felt as if the interview was a test of their factual knowledge or a way of monitoring their clinical performance.[213] In keeping with my non-professional status, the participants did not appear to perceive me as threatening or as someone who would or could judge their professional competencies. This was made clear to me when I interviewed the GP registrar, the most junior of the participants, who was approximately my age, still in her general practice training and who seemed to perceive me as more equal in status than the other participants. This participant, like others, showed uncertainty about whether what she had done was correct but, unlike the others, used her tone and body language to invite me to comment on her practice or to seek reassurance or approval. When the GP registrar left space for me to comment or give approval I attempted to reflect the question back ("and what do you think about that decision now?"). This tended to prompt the registrar to provide two or more alternate views and not give any one of them priority. When I did respond to the invitation to comment or reassure it was usually by evasion "well, it <u>is</u> tricky….", which effectively shut the conversation down. The overall effect was an interview that felt less candid and as if the participant was testing views and opinions against my response in order to say the "right" thing. This was in direct contrast to the confident candour of the other interviews.

A disadvantage of my junior interviewer role is that I may have missed out on insider views or opinions that they may have shared with a fellow GP interviewer. This was highlighted to me in one of the observations of a team meeting. One GP made a joke about a family that indicated exasperation and bemusement and portrayed the mother as dim-witted and incompetent. The joke prompted much laughter from

colleagues. This exasperation and superiority was not present in my interview with this GP when he spoke of the same family.

5.4.8 Observations

I observed four vulnerable families meetings (four hours in total); one from each of the four sites between January and June 2011. During the observations, I was a complete observer. I took no part in the meeting and sat in the corner of the room (not around the table with the professionals). I took structured notes during the meeting, outlining the apparent purpose of the meetings, the content and their tone. I did not audio-record the meetings. My observations were too brief and the analysis too light to be considered ethnography. Ethnography requires considerable time spent in the setting in order to gain a detailed understanding of the world through the eyes of the group or community. Ethnographic methods can generate an insider (emic) account of the setting that is faithful to the perspective of participants and a simultaneous outsider (etic) account which brings in an analytical and theorising view.[159] I conducted brief observations as part of my recruitment process for interview participants and to gain basic insights into the purpose and function of team meetings to discuss vulnerable families, as these had previously been highlighted as a mark of good child protection practice.[87] As I conducted the observations it became clear that they would also give me data that could be used to contextualise and contribute to the analysis of interview data.

5.4.9 Analysis

There are many approaches to analysing qualitative interview data, each with their own strengths and focus. The main approaches that I identified in my literature review are summarised in Table 5-2.

Table 5-2: Summary of qualitative analysis approaches

Method	Distinguishing features	Categorical or Contextualising?*	Strengths	Potential weaknesses
Content analysis.	A basic deductive approach to describe common or recurrent themes (usually) using predetermined categories. Can be used before other types of analysis.[159 188]	Categorical.	Not resource intensive.	Can lead to superficial account.
Thematic analysis.	Aims to identify common or recurring themes which emerge from the text -as complex and sophisticated as the study demands.[159 188] It is seen as an umbrella term for other types of analysis. Sometimes it is argued that this approach is different in that it is not tied to one particular theoretical stance.[211]	Categorical.	Can identify salient issues or typical responses. Flexible in terms of resources.	Can lead to superficial account.
Framework analysis.	Developed for applied qualitative research. Uses a thematic framework to present each case as a summary to produce a matrix of themes for each participant. This facilitates a simultaneous case based *and* thematic analysis. Differs from thematic analysis in its focus on the integrity of each participant's response and on separate data management and interpretation stages.[159 214]	Contextualising and categorical.	Useful when some of the research questions are pre-specified.[159]	Can be reductionist –remove researcher from data.

Table continued overleaf

Table 5-2: *Continued*: Summary of qualitative analysis approaches

Method	Distinguishing features	Categorical or Contextualising?*	Strengths	Potential weaknesses
Grounded theory.	Often seen as a benchmark of rigorous analysis. Aims to generate theory from data using a "bottom-up" approach.[211 212 215] Distinguished by a cyclical process of theoretical sampling and analysis until saturation has been achieved and line by line coding. Characterised by a systematic approach to coding and a constant comparison (also advocated in other methods).[159]	Categorical.	Systematic, rigorous and in-depth. Combined inductive and deductive approaches.	Is very resource intensive.
Narrative analysis.	This term covers a number of approaches to data analysis, all sharing a focus on the way we make sense of the world through stories. The topic of interest is the story. Tends towards poststructuralist orientations (i.e. that there is no stable self behind an author's narrative and that the reader attributes meaning to the text).[188 215]	Contextualising.	Works well for studies with a focus on telling stories.	Does not lend itself well to codifying data.[188]

Table continued overleaf

Table 5-2: Continued: Summary of qualitative analysis approaches

Method	Distinguishing features	Categorical or Contextualising?*	Strengths	Potential weaknesses
Discourse analysis	Seeks to understand the established meanings around a topic and how meanings are constructed through language and practice.[216]	Contextualising.	Good for understanding constructed meanings.	Conclusions might be limited to describing dominant discourse.
Interpretive phenomolo gi-cal anlaysis (IPA)	Central aim is to understand the meaning of events/states for *an individual*. Assumes the data can show us people's involvement in the world, their views and how they make sense of it. Emphasises layers of interpretation: researcher making sense of the participant making sense of the world. Encourages the researcher to take dual stance: empathetic and critical. Characterised by small homogenous groups of participants (sharing an experience).[215 217]	Contextualising.	Works well for exploring lived experience of individuals	Does not suit large sample sizes or high levels of abstraction.

*Contexualised approaches focus on keeping the integrity of the respondents' accounts and interpreting the data in the context of a coherent whole "text" (e.g. analysing Respondent A's account as a unit of data) whereas categorical strategies break down and rearrange the data to facilitate comparisons between respondents.

The choice of qualitative analysis methods reflect both the needs of a particular project and the epistemological assumptions the researcher makes about what the data can tell them. I have largely adopted a thematic approach to analysis because I am interested in recurrent and common themes within a defined group (GPs). A robust thematic analysis can provide a sufficiently in-depth and thoughtful analysis whilst being feasible within my resources.

My approach aimed to be inductive (data driven) and interpretive (rather than simply descriptive).[211] In line with an inductive approach, I made an effort to consciously engage with the literature only in the latter stages of the analysis, though clearly my existing knowledge and thinking could not help but shape the data collection and analysis.[211 212] In many ways, my analysis had much in common with the methodology of grounded theory, except the primary purpose of my study was not to generate *theory* but a rich (thick) description and hypotheses that could inform future research and policy. The inferior status of thematic analysis that Braun and Clark discussed in their 2006 article persists. But, like them, I believe, that a robust and in-depth thematic analysis can be as insightful and skilful as other "branded" analytical approaches.[211]

Although the *way* that individual GPs tell their stories was not my primary topic of interest, my data lend themselves to narrative analysis. I asked the participants to tell me about specific children, young people or families and these stories have a beginning, middle and an end (though often not told in that sequence). I was interested in the types of children and concerns that feature in the interviews and the way that these were depicted by GPs. As such, I used a narrative analysis to characterise the children's stories that were told by the participants and used the stories as a unit of analysis.

I used Nvivo software to manage the data analysis process. First I familiarised myself with the data by reading each transcript and making a table containing a row per "case" containing the main details of the narrative (e.g. nature of the concern, problems in the parents and children, other professionals involved and number of children in the family and my "first impressions" of the story and concepts). Next, I

identified themes by working systematically through transcripts, taking each segment of text and asking “what is this segment about?” and “how is it similar to / different from other segments?” I ascribed each segment a thematic label (a “code”) and, at the end of coding each interview transcript, I reviewed all segments within each code and asked: “Are these segments really similar within and across interviews? Do they relate to any of my other themes?” During this process (known as “open coding”) I generated about 300 codes but as I progressed through the transcripts, the large number of codes became unwieldy and I combined or deleted some and prioritised others for review and memo-writing (detailed notes about meaning and interpretation). To determine which codes to prioritise, I stopped open coding, re-read each transcript as a whole and noted my broad-brush impressions of the interview content and tone. I prioritised codes which reflected these impressions and those which were strongest within the interviews, judged by the number of coded segments and contributing participants for each code. Focusing on the prioritised codes, I organised the codes into larger, more abstract themes and rewrote memos for the themes. Throughout the process, I drew and redrew mind maps (diagrams) to explore how the themes fitted together and to make sense of the data as a whole. They allowed me to see which themes were connected to many others and therefore occupied a central place in the analysis and which were isolated themes (relatively unconnected to other themes) and on the edge of the data. In doing so, the mind maps were instrumental in helping me see which themes were most important in the data and, therefore, which themes should be prioritised for further analysis and inclusion in the thesis (see Appendices 5.3 and 5.4 for two examples of the mind maps).

To ensure that my analysis generated robust and credible results, I used techniques which have been highlighted by qualitative methodologists as good practice for all qualitative analysis within my overall thematic approach. Table 5-2 describes these elements of good practice, which I generated from my literature review of qualitative methods.

Table 5-3: Characteristics of good qualitative data analysis

Conducting simultaneous data collection and analysis (analysis not distinct phase; keeping memos and field notes).
Interpreting data in the local circumstances in which it was produced (context).
Systematic coding / analysis (all data considered not just cherry picked).
Using an inductive / deductive approach: a combination of exploring the themes and assumptions with which you started the study and allowing the data to generate its themes and concepts.
Constant comparison between cases / units.
Looking for “deviant” cases either in already collected data or by sampling according to emerging theories in order to extend/modifying these emerging theories.
Building theory from the data: moving from specific ideas in the data to a unifying concept that has a wider meaning.

*This list was developed from a literature review that included all approaches

In addition, within my overarching thematic approach, I have included techniques that are commonly associated with other analytic approaches. I used: an open coding stage to fracture the data, generate new ideas and develop the initial coding framework (usually associated with grounded theory approaches); constant comparison of segments within and between interviews (grounded theory); initial familiarization with the data using a "mapping" approach (framework analysis), and both concepts and narratives about children or families as the unit of analysis (grounded theory and narrative analysis, respectively). It is common for qualitative research to draw on a range of techniques within one overarching approach to analysis, as I have done here.

Although my primary aim was to generate themes from the interview data about GP responses to maltreatment-related concerns, I also had an a priori interest in two types of responses: recording of concerns and the team meetings to discuss vulnerable families meetings. My a priori interest in these two responses led me to actively look for relevant data and to prioritise inclusion of these responses in the results chapter. The first, "recording of concerns" is an obvious area of overlap between my quantitative analyses that use data from electronic health records (reported in Chapter 4) and the in-depth qualitative data. I made a point of asking about recording in the interviews if participants did not mention it themselves. The second "vulnerable families meetings" was a point of interest because, although these meetings have been highlighted by the RCGP as a model of good practice, there is very little detail available in the literature about their purpose, attendees or functioning. I had an opportunity to add to this knowledge via my observations of four of these meetings in four different practices.

MB, an experienced qualitative researcher and one of my PhD supervisors, independently coded two of the transcripts and discussed her ideas with me.

5.4.10 Gaining feedback on results from participants

Gaining feedback from respondents on qualitative study results has traditionally been termed "respondent validation" or "member checking". I have deliberately avoided this terminology as it suggests that study results can be "validated" or "checked" by asking the participants whether they agree with them. If you are coming from a constructivist stance as I am (see Chapter 5, section 5.4.7, p.182 for further details), then it does not make sense to try and "validate" results of a qualitative study. From a constructivist stance, it make sense to anticipate differences between the way that the researcher and the participant would interpret data and between what a participant may say or imply in an interview and what the same participant may say when asked to feedback on results and interpretation of these results. Instead, as other qualitative researchers have pointed out,[159 218] participant feedback can be seen as a way of generating *new* data. It tells us how far participants see the results and interpretation as reflecting their own experience and views and whether there is anything that is particularly acceptable or objectionable to them in the portrayal that the researcher has produced. I approached feedback to participants as new data that shaped the final interpretation of the results.

I fed back results to each of the 17 participants using a hard copy of a one-page information leaflet. The leaflet explained the purpose and methods for feedback, gave very brief results of the study and asked some simple questions to guide feedback. The questions varied for the three professional groups (GPs, health visitors and practice nurses), each of whom were each sent their own version of the leaflet. The questions for GPs were:

- How far do you recognise the four types of families? Do they reflect your child safeguarding workload?
- Do the four responses reflect what you do for families with maltreatment concerns (in addition to referring to and working with children's social care)?

- Do you consider the four responses part of “normal” GP practice (i.e. are these strategies you routinely use for other patients)? If so, which patients?
- When used in response to maltreatment concerns, would you see the four responses as :
    - “safeguarding” work?
    - “child protection” work?
    - something else?
- Do you have any other feedback?

The questions for health visitors and practice nurses were rephrased to ask about “GP practice” and there was an additional question asking whether these professionals perceived themselves to use the responses that we had identified among GPs. Appendix 5.5 contains the GP version of the leaflet. The leaflets and letters were sent out in the first class post on 25th November 2012 and participants were asked to feedback before 17th December 2012 and an email reminder was send on 17th December to those who hadn’t yet responded. In total, seven (41%) of the participants emailed me with feedback, including five GPs, one health visitor and one practice nurse. At least one participant from each data collection site gave feedback. In their emails, three of the participants directly answered the questions on the leaflet. The remaining four gave more general feedback, some of which addressed some of the questions in the leaflet. In the relevant results sections of Chapter 6, I have indicated where participant feedback supported or challenged the analysis and where it influenced the way in which I framed or presented results.

5.4.11 Literature reviews undertaken to contextualise my findings

As mentioned above, I deliberately postponed wider reading of relevant literature until the latter stages of analysis. Before this point I had not specified *how* I would contextualise my findings using existing literature. I did not limit myself to reading within a particular discipline (e.g. epidemiology or sociology), within a particularly area

of healthcare (e.g. secondary or primary healthcare), to a specific age of patient (e.g. children or adults) or to a particular type of patient problem (e.g. child maltreatment, cancer or heart disease). Instead, I used an iterative approach, starting with literature that I knew existed and which was obviously relevant, such as Tompsett's mixed method study into the role of the English GP in child safeguarding.[61] This was supplemented by key word searches of the PubMed, Google and Google Scholar using terms that reflected certain elements of my findings.[*] Finally I asked colleagues if they could recommend literature to me. I used reference lists of the relevant studies to generate further avenues and used a great deal of judgement in deciding which paths to pursue and for how long. This approach is similar to that described as "snowballing" by Trisha Greenhalgh[156] and was designed to help me to generate deeper meaning from my findings.

In addition to the exploratory reading described above, I also conducted a more structured (traditional) literature review of parent, young person, adolescent and child views of the GP-patient relationship. This was for two reasons. First, the results from my qualitative study suggested that a strong and trusting doctor-patient relationship might be a necessary facilitator of GP responses to maltreatment-related concerns. The pervasive theme of "trust" in the doctor-patient relationship raised the question: do parents and children experience the GP-patient relationship in a way that might give GPs a credible chance of successfully enacting the kinds of responses which I identified in my qualitative study. Indeed, this was the most pervasive theme within the data. Secondly, the views of parents and children were otherwise absent from my PhD study.

[*] For example, one important theme in my qualitative data was the theme of chaotic, "on the edge" families who prompted maltreatment concerns among the GPs I interviewed. I searched for relevant literature using the terms: ((social adj (problem OR welfare OR need)) OR (vulnerable OR chaotic OR (at adj risk) OR safeguarding)) AND (GP OR (General adj Practitioner) OR (primary adj care) OR doctor).

5.4.11.1 Literature view on views and experiences of parents, young people, adolescents and children

I conducted a literature review asking the question: how are GP services in the UK seen and experienced by parents, young people, adolescents and children?

I included any study which collected data in 2004 or later in any of the four UK countries and interpreted 'the doctor-patient' relationship broadly to include relevant themes such as continuity of care, empathy or listening skills or the role of the doctor in responding to social problems. In order that I understood views and experiences of the GP-patient relationship in the context of views about other professional groups, I briefly extracted data about all professionals from the included studies. I have provided full methods, including inclusion criteria and search strategy in Appendix 5.6.

Although I do not claim that my strategy for contextualising my findings using existing literature was either comprehensive or systematic, neither was it scatter-bomb. It was not the most direct way to the end point but it did lead to interesting discoveries.

5.5 Ethics

5.5.1 Ethics approval and research governance

Ethical approval for the interviews and observations was given by Central London 1 NHS Research Ethics Committee on the 8th October 2010 (Reference 10/H0718/6; see Appendix 5.7 for approval letter). Major amendments for a fourth data collection site and to out-source transcription of interviews were approved by the same committee in early 2011.

For each of the four sites, approval was given by the relevant Research and Development Unit of the Primary Care Trust (PCT) who issued a Letter of Access permitting me to conduct the research in the specified sites within the given dates (see Appendix 5.8 for anonymised example of a Letter of Access).

My study was included on the Clinical Research Network (CRN) Portfolio (http://public.ukcrn.org.uk/Search/StudyDetail.aspx?StudyID=8683). The CRN provided

guidance and the local CRNs liaised with the PCTs to facilitate approval of my study. I sent recruitment data to the CRN each month until recruitment was complete. This data are used to inform the allocation of NHS infrastructure for research (including costs) and supports audit of CRN activity.

The study was registered with UCL records Office and is covered by the UCL Data Protection Registration, reference No Z6364106/2010/07/06, section 19, health research. The study is included on UCL's insurer's Clinical Trials Policy, which provides appropriate insurance for any harms arising out of the study (reference 10/0219). A risk assessment (for risk to myself) was completed and signed off by the head of Estates and Facilities at UCL-Institute of Child Health.

5.5.2 Ethical procedures

Information on the procedures to maintain confidentiality, ensure informed consent and securely store data are all detailed in the protocol which I submitted for ethical approval (reproduced in Appendix 5.9). These proposed procedures were all followed during the study. Contact details for discussion of professional or personal issues arising from the interviews (the "safeguarding lead" in the practice and the PCT counselling services, respectively) were provided on the Participant Information Sheet (copy provided in Appendix 5.1).

A reciprocal approach

Aware that participants were giving up their scarce and valuable time without any immediate reward, I tried to maximise the reciprocity of my relationship with them. I offered participants a letter which could be used as part of their revalidation portfolio and all participants but one accepted this (see Appendix 5.10 for an example letter). I ensured I fed back my results to the practices (see section 5.4.10, p. 195 for more details) and informed participants when there were delays to the progress of the study and when the results were published in an open access journal.

To allow participants control over their stories, I offered to send them the transcripts for approval. Only three participants wished to see their transcripts and they were all approved without feedback. However, one participant expressed a high level of concern that one family she discussed could be identified due to the rare nature of events in the story. We agreed that I would not use this particular story in any publications or presentations and that output from the study would be shown to her first. I have since emailed presentations to this participant but not received any feedback.

5.6 Key points from Chapter 5

- I conducted interviews with GPs (N=14), health visitors (N=2) and practice nurses (N=2) from four GP practices in England and observed team meetings (N=4) at the same sites.
- Interviews were free-ranging discussions about children, young people and families whom had prompted "maltreatment-related concerns". Minimal guidance was given to the participants about selecting families for discussion; I specified only that the participant knew enough about the concern/family to discuss it in-depth.
- Eight of the interviewees were "experts" in child safeguarding and because of this the four GP practices could be considered to have more than average expertise in this area.
- I argue that I successfully elicited "private" accounts which went beyond the socially/professionally acceptable: I did not just hear what GPs thought they should do.
- I conducted a thematic analysis within an inductive and interpretive approach.
- I used an explorative approach to contextualising my findings in existing literature with the exception of a more structured review on one topic: the GP-patient relationship from parental, young person, adolescent and child perspectives.

6 CHAPTER 6: Who are GPs responding to, what actions are they taking and what are the relationships that help or hinder these actions?

Statement of authorship

All the work presented in this chapter was designed, undertaken, analysed and interpreted by myself and is published as a journal article[219] and as a report written for the NSPCC.[10] The journal article is reproduced in Appendix 9.5

6.1 Content and structure of chapter

This chapter contains the results and discussion for the qualitative data collection and analysis (phase 4). The background and methods for this part of the study can be found in Chapter 5.

During analysis, it became clear that the interview and observation data answered three overarching questions and I have grouped the findings into three sections which relate to these questions:

- **Who were the GPs responding to?**

  This section (section 6.2) has three parts:

  - What triggered maltreatment-related concerns?
  - Typology of families: which families prompted a response?
  - Responsibility and involvement: why *these* families?

  Overall, this section also provides insight into the question: how did the GPs conceptualise a "maltreatment-related concern"?

- **What actions were the GPs taking?**

  In this section (section 6.3, p. 230) I briefly outline the seven actions that the GPs described taking. Full details of the actions are reported in Appendices 6.6 to 6.12.

- **What were the facilitators and barriers to the GPs' actions?**

  In this section (section 6.4, p. 240), I present a detailed analysis of themes related to relationships between GPs and patients and GPs and other professionals. These themes provide insights into potential barriers and facilitators of relevant GP actions.

The themes within the three sections are intrinsically inter-related: the actions that the GPs described varied according to the type of family and their problems and actions were seen to be facilitated or hindered by relationships between GPs and parents and between GPs and other professionals. I have used diagrams to summarise the relationship between types of families, actions and facilitators and barriers to actions.

To make my results a manageable length, I have had to give some aspects of my results more space than others. Specifically, I have attempted to summarise my analyses of the types of families and GP actions rather than presenting the full and in-depth analysis. On the other hand, I have presented the sections about responsibility and involvement (why these families?) and doctor-patient and inter-professional relationships in full (barriers and facilitators). The themes presented in full were the most complex and multi-faceted element of GP responses in my data and were concepts on which all the other findings hinged. I have used appendices to provide a fuller explanation of the sections that I have summarised.

To aid navigation of this long chapter, I have used 'key points' sections for higher order sub-sections and where sub-sections contain very detailed results, I have used 'summaries'.

I end this chapter by interpreting my findings in light of existing evidence and the strengths and weakness of this component of my PhD study and outlining the key points from the entire chapter. Conclusions and implications for practice and policy and research can be found in Chapter 8.

6.2 Who were the GPs responding to?

In the 17 interviews, participants discussed a total of 37 families. The majority of participants spoke about two families (range 1-3 families per participant). Most participants had several cases in mind for the interview and only one participant (a GP) struggled to think of more than one relevant case.

Participants spoke about children of all ages, ranging from unborn children to those who were 18 years old. However, only a minority of children discussed were at either end of the age spectrum. There were eight adolescents discussed (aged 13 years or over). Two of these were the oldest child in large families of children and, in both cases, all the children in the family had elicited professional concern.

As I am interested in *GP* responses to maltreatment-related concerns, rather than responses from health visitors or practice nurses, this section draws exclusively on data from the 14 interviews with GPs. The exception is the typology of families which, as there was little difference between professionals, uses data from all 17 interviews.

This section is divided into three parts, each covering a theme related to the families that the GPs described in their interviews:

- What triggered maltreatment-related concerns?
- Typology of families: which families prompted a response?
- Responsibility and involvement: why these families?

6.2.1 What triggered maltreatment-related concerns?

Many of the concerns that GPs described were long-standing. The following section is based on what the GPs told me about the most recent contact or an event which either prompted a new concern, or renewed or intensified an existing concern.

Table 6-1 shows that concerns were most frequently triggered by contact between the GP contact and the parent. Consultations with the child and information/referral received from another healthcare professional or from children's social care were also described as important prompts for concern.

In the child consultations, just over half the presenting complaints (N=5/8) *directly* prompted the GP concern. In the remaining three cases, concerns were prompted following observation of child and mother during the consultation and collecting wider information from the mother and/or the child's medical notes.

In the majority of the cases where concern followed a parental consultation, the presenting complaint *indirectly* prompted the concern. For example, after several consultations, one GP saw that a mother's poor compliance with treatment for her own chronic health problem was indicative of her chaotic lifestyle and a symptom of her alcohol misuse, which then raised questions about her parenting capacity. Information from other agencies was interpreted by GPs in the context of their existing knowledge and it was the combination of multiple pieces of information which gave rise to the concern. For example, a discharge letter reporting a teenager's admission to hospital due to alcohol poisoning was interpreted as particularly worrying in light of the GP's very long-term concern about neglect in this family. Table 6-1 provides a more detailed summary of the ways in which GPs told me concerns had arisen.

Table 6-1: What triggered maltreatment-related concerns?

How did GP's current concern arise?	N of families*	Additional information
Child consultation	8	In five cases, the children presented with symptoms that directly prompted the maltreatment-related concerns (e.g. teenage pregnancy or failure to thrive). In the remaining three cases, the reason for consultation was unconnected to the concerns (e.g. chest infection or gastroenteritis). In these cases, the consultation gave opportunity for the GP to observe the child and/or parent and collect wider information, giving rise to concerns. All eight cases had a history of GP concern.
Parent consultation	12	In three cases, the mother disclosed domestic violence to the GP during a consultation about a related medical problem (e.g. depression). In seven cases, consultations with the mother prompted concerns from the GP about the mother's capacity to parent (e.g. a home visit for "flu" which revealed alcohol misuse). Finally, in two cases, the parent came to see the GP because they were worried about their child's mental health (e.g. self-harming) or about their own capacity to parent.
Information from other professional	6	In two cases the child was referred from the health visitor or practice nurse to the GP for a second opinion about injuries and in a further case social care had referred the child to the GP due to behavioural problems. In one case, I inferred that the referral had come from social care as it concerned a very serious and possibly non-accidental injury in a young baby. In the remaining two cases, concerns arose following letters received from other healthcare services. The GPs interpreted these letters in the context of wider and/or historic information about the family. Most but not all of this information resulted in a consultation with the child.
*This table is based on the 26 families discussed in the 14 interviews with GPs. In many cases the families had a long history of professional concern and it was not clear from the interviews how the families first prompted maltreatment-related concerns from the GP. The data in this table are based on what the GPs told me about the most recent contact or an event which prompted renewed concern. I had to use a large amount of judgement in classifying how concerns arose.		

6.2.2 Typology of families: which families prompted a response?

From the narrative analysis of the cases described by the participants, I created a typology of families. Although these typologies of families help us understand GP perspectives and understandings of their own role and practice in responding to maltreatment-related concerns, it is important to remember that they cannot be relied on as an accurate summary of the families themselves. I identified four narratives describing four types of families, which I named using *in vivo* codes (i.e. quotes from participants):

- **"Stable at this point in time but it's a never-ending story"**: narratives describing families with previous very serious maltreatment-related concerns who had since achieved a fragile stability that required extra vigilance from participants. The main concern was usually about possible neglect and emotional abuse.

- **"On the edge"**: narratives describing families who were barely coping and liable to tip over the edge at any moment. The main concern was usually about possible neglect and, in some cases, emotional abuse.

- **"Was it, wasn't it?"**: narratives describing situations where participants had a high degree of uncertainty as to whether physical or sexual abuse had taken place and where much time was spent trying to establish whether the suspected abuse was likely to have occurred.

- **"Fairly straightforward"**: uniformly brief narratives in which there was high certainty about physical abuse and decisive onwards referrals.

Table 6-2 presents an overview of the typologies and Appendices 6.1 to 6.4 give a more detailed description of each of the types of families using participants' own

words. The types of families are key to understanding the other themes in the data and throughout the chapter (and thesis) I refer back to the typology.

Table 6-2: Summary of typology of participant narratives about families

It important to remember that these typologies of families only tell us about GP perspectives and understandings and not about the families themselves. See Appendices 6.1-6.4 for a detailed description of each of these family types in participants' own words.

"Stable at this point in time but it's a never-ending story"	**"On the edge"**	**"Was it, wasn't it?"**	**"Fairly straightforward"**
Most common narrative • Very serious and long-term parent drug/alcohol use, mental health problems and domestic violence. • Extensive contact with child protection services, police and drugs and alcohol services.. • Siblings taken into care or died • Concerns about physical neglect and emotional abuse. • Circumstances seen to have recently improved for children. • Participants felt hopeful about capacity to parent in the future. • But new stability was seen as fragile and optimism about future was cautious and uneasy. • Perceived need for continued vigilance to spot relapses (further neglect / emotional abuse) and prevent poor child outcomes.	*Second most common narrative* • Lack of boundaries for children; poor school attendance, missed medical appointments, concerns about nutrition and clothing Families experienced: poor housing; unemployment; poverty; parental alcohol use or mental health problems; and child health and behavioural problems. • Concerns about physical/ medical neglect and emotional abuse. • Families came often to the GP for problems (help-seeking). • Accounts of intermittent and inadequate involvement from child protection services. • Children described as 'vulnerable' and as currently involved with child in need services. • Worry about families "tipping over the the edge" at any moment.	*Third most common narrative* • Concerns focussed on possible physical or sexual abuse. • Participants were very uncertain whether suspicions "amounted to anything or not" and believed that physical or sexual abuse were a possible but unlikely differential diagnosis. • They described having just enough concern to take further action. • After varying amounts of time (from a few days to over a year), participants reached the decision, usually in conjunction with children's social care, that the child was *not* likely to have been physically or sexually abused. • However, in the four stories of injured children, participants described on-going concerns about supervision (i.e. neglect).	*Least common narrative* • These narratives were characterised by concerns about maltreatment described as "obvious" or "barn door" with a high level of suspicion from participants and decisive referrals to social care or secondary health care. • Narratives were characterised by participants believing that referral to social care or other agencies would result in appropriate and timely services. • These cases were only mentioned in passing and usually as a contrast to one of the other family types, about whom participants talked in detail and at length.

Not all the 37 narratives fitted neatly into the typology above. A discussion of these families is presented in Appendix 6.5.

The most common narratives and those that occupied most talk-time were those of "stable at this point in time" and "on the edge" families (Table 6-3).

Table 6-3: Frequency of each family narrative in the typology

N of narratives	Typology of narratives about families				
	Stable at this point in time	On the edge	Was it, wasn't it?	Straight-forward	Not able to classify
	16	12	9	3	7

*In total, 37 families were discussed by 17 participants. The number totals 47. This is because some families were discussed by different participants (and classified as different family types) and because some narratives about families from a single participant shifted from one type of family to another over time. For more information on narratives that shifted over time and those which were outside the typology, see Appendix 6.5

These narratives, and consequently the interviews, were dominated by accounts of child neglect (physical or medical) and emotional abuse (Table 6-2). The "was it, wasn't it?" stories were the third most common type of family discussed in the interviews. These concerns centred on possible (but unlikely) physical or sexual abuse. Although the "was it, wasn't it?" narratives were typified by concerns about physical and sexual abuse (Table 6-2), almost half of these narratives (N=4/9) transformed into stories about possible neglect (inadequate supervision) when non-accidental injury was ruled out. Neglect and emotional abuse were not mentioned in the few "fairly straightforward" narratives (N=3; Table 6-3) to which very little talk-time was dedicated. These narratives centred on physical and sexual abuse, which was considered to be "obvious" by participants.

In narratives that I categorised as about physical and sexual abuse, the participant either directly labelled the maltreatment ("physical abuse", "non-accidental injury" or

"sexual abuse") or described violence against a child, possible sexual activity between a teenager and an adult family member and/or specific genitourinary symptoms which they considered suspicious. In contrast, not all the narratives about emotional abuse or neglect were so explicitly labelled. Although, some participants used the term "neglect", others described child symptoms or parental behaviours which I interpreted as concerns about neglect. In these cases, children were described as "smelly", "dirty", "unkempt", "freezing [because not properly clothed for the season]", "failing to thrive" or at risk of malnutrition or dehydration due to parenting. Parental behaviour was described in terms of "low parenting capacity", "poor parenting" or "impoverished" parenting. Participants reported how these parents failed to supervise the children adequately, transferred parenting responsibilities onto older siblings who were themselves young children, failed to set boundaries, routines or bedtimes, frequently failed to take children to school and/or did not adequately comply with essential medical care for their children. In these cases participants tended to worry about the longer term consequences for the child, such as delayed development which would only be apparent with starting nursery or school, future teenage pregnancy, future drug-use/ other risky behaviour, and/or poor educational outcomes and future employment prospects. GPs recognised behavioural and mental health problems as possible short to medium term consequences of these problems. For the concerns that I classified as about emotional abuse, the participant explicitly labelled the concern as such or referred to the psychological or emotional impacts on the child of witnessing domestic violence or of parental alcohol and/or drug abuse.

Appendices 6.1 to 6.4 give a fuller explanation of the types of families and concerns, supported by quotations from the interviews. These appendices also contain brief details of the perceived consequences of the (possible) maltreatment, by family type.

6.2.3 Participant feedback relevant to typology of families

For participants who gave feedback on provisional results, the typology of families appeared to be a recognisable and acceptable portrayal of the types of families to

whom GPs were responding as a result of maltreatment-related concerns. The exception was a heath visitor who expressed surprise at the fact that the GP narratives were dominated by neglect and emotional abuse and stated that, in her opinion, GPs largely focused on non-accidental injury. Feedback from this participant is discussed further in this chapter (section 6.4.3.4, p. 261)

6.2.4 Key points from typology of families

- Children were described in the context of their family. Most of the maltreatment-related concerns described in the interviews had arisen following consultations with parents about their own health problems, although concerns were also generated (or renewed or intensified) following consultations with children and/or information from other agencies.

- Concerns were often generated by placing together multiple pieces of information, including knowledge of the family built up over several years and from multiple family members.

- The families who were discussed in the interviews could be categorised into a four part typology. “Stable at this point” and “on the edge” families were discussed with highest frequency and occupied most talk-time. For these families, participants could give a high level of detail about multiple family members, often reaching many years back. As these two family types prompted concerns about neglect and emotional abuse, these problems dominated the interviews.

- Concerns about neglect and emotional abuse were often long-standing and, for “on the edge” families, were hovering around or below the thresholds for social care child protection intervention.

6.2.5 Responsibility and involvement: why these families?

In the following section, I present hypotheses about why GPs might be responding to *these* families by describing the concept of "responsibility and involvement" which emerged from the interview data.

When I asked GP participants the question "And why have you chosen this family to discuss with me today?" the responses included:

- That it was a particularly "difficult", "challenging" or "complex" case or a situation where the GP was uncertain about how best to proceed.
- That it was typical of their maltreatment-related workload.
- That it was a case which had taken/was taking a lot of their time and energy.
- That this case was fresh in their mind due to a recent contact with or about the family.

A more illuminating answer to this same question was uncovered by analysing variable involvement from participants in the maltreatment-related concerns they described, along with differing levels of perceived responsibility. The second part of section 6.2.5 below explores the concept of "responsibility and involvement" in order to understand why GPs described responding to *these* families.

For "stable at this point", "on the edge" and "was it, wasn't it?" families, participants portrayed themselves as having active and significant responsibility for the families' social welfare and for any maltreatment-related concerns. This involvement and responsibility was in stark contrast to the limited involvement and lack of responsibility that typified participants' roles in "straightforward" concerns. Further analysis generated three important themes related to responsibility and involvement: "we'll always have a very medical role for this family", "I was sympathetic to them" and "inappropriate involvement from other agencies".

6.2.5.1 "We'll always have a very medical role for this family"

This theme captures two ideas that were central to participants' taking responsibility for maltreatment-related concerns in their narratives about "on the edge" and "stable at this point" families. First, the portrayal of high health need in parents was seen to offer opportunity for identification of social welfare concerns in children and justification of on-going involvement from GPs. Secondly, GPs constructed neglect as a medical problem.

Health need as legitimate opportunity for intervention

High physical and mental health needs among parents and children dominated the participants' narratives about "on the edge" families. Participants highlighted how health problems in these families, usually in the mother, resulted in regular contact with the family which allowed maltreatment-related concerns to emerge over time. Concerns arose from participants' understanding of the parental health condition or the patient's ability to manage it:

> "A lot of their needs and my concerns about their needs has been her inability to be a good enough mother because of her own mental health needs."
>
> *(Participant 10, GP, Family 26, 3 children 9-16y)*[*]

> "And I can't remember how we actually got the child protection issues but I think it was probably – I mean I was so worried about this girl [the mother] and the fact that she was completely disorganised in her life."

[*] In the parenthesised description below the quote, I list the participant number and profession (GP, health visitor or practice nurse), age and number of children who were a cause for concern, and any other siblings that the participant described but who did not seem to be the focus of professional concern.

(Participant 2, GP, Family 7, 2 children aged 2 and 3y)

Or as mothers gradually disclosed information to the GP when they were consulting for their own health needs:

> "And then it became apparent that there were a lot of problems within the marriage. And this all culminated in a lot of domestic violence."
>
> *(Participant 10, GP, Family 26, 3 children 9-16y)*
>
> "…what came out of the conversations was that there was some problem with the relationship with her husband which was occasionally abusive in that – verbally at least."
>
> *(Participant 2, GP, Family 7, 2 children aged 2 and 3y)*
>
> "I'd been seeing her for the last six months [for mental health problems], that is the first time after six months she opened her mouth, this [domestic violence] is happening."
>
> *(Participant 15, GP, Family 36, children aged 9 and 11y)*

These narratives depicted high health need, usually in parents, as providing opportunity for identification of social welfare need in children of "on the edge" families. The GP's role was defined in terms of identifying and meeting health needs of parents (and sometimes children) with a *secondary* role of safeguarding which built over time.

The focus on *medical* problems and *medical* responses was present throughout the interview data for "on the edge" and "stable at this point" families. Participant 5

justified his on-going involvement with an "on the edge" family in terms of meeting their health needs and only secondarily in terms of social welfare concern. He represented the GP's safeguarding role as ill-defined and uncomfortable and justified on-going involvement first and foremost in terms of *medical* need:

> Interviewer: "And what do you think is your role as a GP for...for them?"
>
> Respondent: "Well, I...I...I think that we'll always have a very medical role for this family. They're very...they have very great medical needs so they...that's kind of...although it's difficult, is the relatively easy bit. I mean, how we tap into the sort of welfare issues of families and children, I think is, um, much more difficult, much more difficult."
>
> *(Participant 5, GP, Family 15, 4y old child with four siblings)*

Similarly, Participant 0 is quite emphatic that her follow-up of a "stable at this point" family is for medical and not social reasons, as she corrects my inference by using the word "medical" three times in two sentences. Implicitly, she suggests that the medical need provides a *legitimate* opportunity to respond to maltreatment-related concerns:

> Interviewer: "Did you ask them for this appointment this afternoon; is that because of the social concerns?"
>
> Respondent: "No, it isn't social concerns actually it was failure to thrive concerns. It is a medical reason. I wanted to see if she really was going off her centile or not and whether this, I mean it might have been medical needs [..]. It was a *medical* reason but I have got these social, developmental reasons in my mind, they have already been highlighted and I think they are already being dealt with but I need to keep the social, I do need to keep that safeguarding in mind."

(Participant 0, GP, Family 3, 4y old child with two older siblings, original emphasis)

Participant 7 was more explicit in her opinion that follow-up appointments for maltreatment-related concerns alone are *not* a legitimate part of the GP's role:

> "…obviously there are times when we say, no I want to see you again, so where we arrange the follow up, but arranging follow up for the purposes of reviewing concerns around umm, safeguarding, I wouldn't see as part of our role."
>
> *(Participant 7, GP, Family 19, 2 children aged 6 and 10y)*

With varying degrees of explicitness, Participants 0, 5 and 7 used the concept of medical need to limit the scope of the GPs safeguarding role: they framed and understood their responses to maltreatment-related concerns within the context of responses to medical problems. Other participants dealt with the contested role of involvement in social welfare concerns by implicitly subsuming responses to maltreatment-related concernswithin a medical framework. This was evident when participants compared their responses to maltreatment-related concerns to other elements of routine GP work such as care of the elderly (Participant 12), terminally ill patients (Participant 14) or vulnerable populations such as those with drug or alcohol misuse or dementia (Participant 5). These GPs presented responses to maltreatment-related concerns as "nothing out of the ordinary" (Participant 4, quote taken from observation of team meeting).

However, elsewhere in the data, this neat distinction between "medical" and "safeguarding" was explicitly challenged. "On the edge" families were described as presenting indiscriminately with health and social welfare need:

> "They used to come for their medications. They used to come for all these letters for social services, letters for something, housing, benefit or something or something."
>
> *(Participant 15, GP, Family 35, 2y old child)*
>
> "I am the person to whom they turn at every small opportunity with, you know, benefits problems, psychological problems, physical problems, housing problems."
>
> (*Participant 10, GP, Family 26, 3 children 9-16y)*

Because of the complex mix of problems that patients bring to the GP, Participant 10 saw herself as having to step outside the legitimate and comfortable role of health into a more contested social welfare role:

> "… maybe we should just be saying, well, I'm sorry, but there's nothing I can do or, you know, I am the GP, I'm not the social worker. If she's not going to school, you know, you'll have to phone social services or somebody else who can do this, because that's not my job. And maybe we sort of just blurred boundaries too much by taking on work that possibly isn't really appropriate for us to do."
>
> (*Participant 10, GP, Family 26, 3 children 9-16y)*

In summary, participants present the health needs of "on the edge" and "stable at this point" families as providing legitimate opportunities for on-going contact and uncontested entry into responding to concerns about abuse or neglect. Some participants strove to delineate medical and social welfare needs and responses in their patients but, in practice, there seemed to be a blurring of the two that placed the

GPs in a role that they felt was disputed and experienced as uncomfortable. Framing safeguarding responses within 'medical' responses and normalising safeguarding within the context of their wider job were the ways that the GPs neutralised their contested role in safeguarding and justified on-going involvement and responsibility. However, uncertainty about the relative activities of "medicine" and "safeguarding" could also lead to a conceptualisation of the problem as "not my job" (Participant 10). There seemed to be a situation where GPs could choose whether to frame maltreatment-related problems within a medical model and take on-going responsibility, or to conceptualise these problems as outside of their medical remit and place responsibility exclusively on the shoulders of children's social care.

The conceptualisation of neglect as a medical problem

The GPs also described the physical health consequences of medical neglect in ways that seemed to justify involvement with these maltreatment-related concerns. Depictions of (possible) neglect and emotional abuse dominate participants' narratives for all of the "on the edge" and "stable at this point" families (Table 6-2) and specific points of intervention for these families centred round the consequences of parental failure to treat health conditions in the children (medical neglect):

> Interviewer: "And can you think of an example where you've perceived an increased need in the family and tell me what you've done to try and meet those needs?"
>
> Respondent: Yes, I think the best example of that is where T [the child] has gone through a really bad phase with infected eczema, with her skin problem, getting worse and reaching crisis point [because her parents were not giving her the regular treatment] And so […] we've been able to step up the frequency with which we see them."
>
> *(Participant 4, GP, Family 13, four children 3-13y and six older siblings*)

> "So I actually got a letter from the optician recently and it said, this girl's vision in this eye is getting worse and worse. Unless something is done soon she's going to lose her eye [because the parents are not complying with treatment or taking her to appointments]. So I actually rang the mother up."
>
> *(Participant 5, GP, Family 15, 4y old child with four siblings)*

In answering my question about why he had chosen a particular family to discuss, Participant 4 was explicit about the conceptualisation of neglect as a medical problem:

> "I think they reflect first of all the great prevalence of neglect as a problem – as a social problem, but partly as a medical problem as well."
>
> *(Participant 4, GP, Family 12, 2 y old child)*

Overall, participants tended to portray their management of neglect in terms of a response to a medical rather than social problem. This seemed to be another way in which GPs neutralized their contested role in responding to maltreatment-related concerns and justified on-going involvement and responsibility. Along with the higher prevalence of neglect in the community, the conceptualisation of neglect as a medical problem might explain the dominance of this type of maltreatment concern in the interview stories.

6.2.5.2 "I was sympathetic to them"

This theme captures the relationship between feelings that a family was deserving of help and a participant's on-going involvement with maltreatment-related concerns. This is the second important idea relevant to participants taking responsibility for and getting involved in maltreatment-related concernsin "on the edge" and "stable at this point" families.

Participants described feelings sympathetic towards "on the edge" and "stable at this point" families. The sympathy seemed to arise from a feeling that poor parenting could be explained or justified:

> "I thought they [the parents] had some sort of excuse, I was sympathetic to them."
>
> *(Participant 0, GP, Family 3, 4y old child with two older siblings, describing how she suspected that two drug using parents were self-medicating for bi-polar disorder)*

The exoneration of poor parenting tended to be rooted in descriptions of the parent's own background. In the context of their own difficult childhoods, mothers were described as child-like, as needing "parenting" and as being "incapable" of better parenting through "no fault of her own" (*Participant 2 and Participant 10).*

The sympathetic attitude to these families was also evident in the descriptions of the mothers as:

> "loving" *(Participant 2, GP, Family 2, children aged 2 and 3y)*
>
> "caring" (*Participant 12, GP, Family 31, 2 children aged 3 and 7y)*

"a good mum" *(Participant 7, GP, Family 18, 13y old child)*

Mothers were described in these terms despite the serious consequences of child neglect outlined in their narratives.

The sympathetic view of mothers was a key feature of narratives in which the participants described engaging with families. It was directly connected to participants' motivation to remain involved rather than pass responsibility to another professional or agency:

> "I could've easily just said, "Oh, I'll see your own doctor to contact CAMHS [Child and Adolescent Mental Health Services] or whatever," but I just did it for her because I actually believe her story if you like and I was sympathetic to what she was saying. So that's why I did it for her."
>
> *(Participant 11, GP, Family 11, teenaged daughter)*

Participant 2 was explicit about how it was necessary to *deliberately* cultivate this sympathetic view of parents:

> "What you've got to do with people whose behaviours aren't helping themselves, I think, is you've got to look beyond and try and find something you like about the person to work with it to try and help them."
>
> *(Participant 2, GP, Family 7, 2 children aged 2 and 3y and mother pregnant)*

The sympathetic view of "on the edge" and "stable at this point" where parents were seen as "loving" but incompetent was less compatible with physical and sexual abuse, which were seen to be deliberate and "malicious":

Respondent: "So neglect is often a – is sometimes – is often not malicious. It's usually due to poor functioning parents, whereas malicious wounding of a child I think – I find more difficult personally because my own emotions start to take hold.

Interviewer: And what emotions are they?

Respondent: Well, disgust and I just find it difficult to be sympathetic towards a parent that can do that with their child really. And I – working with them it would – I would be slightly more arms-length with them I think."

(Participant 2, GP, Family 7, 2 children aged 2 and 3y and mother pregnant)

In summary, an understanding of maternal history and family context drove depictions of neglectful mothers as vulnerable and exonerated. This construction of neglectful mothers allowed participants to take a sympathetic view of them which in turn facilitated on-going engagement with the maltreatment-related concerns in these families. This relationship between family history and historical context, neglect, sympathy and professional engagement may explain why participants passed on responsibility for "straightforward" families to other agencies while keeping some responsibility for the concerns in "on the edge", "stable at this point" and "was it, wasn't it?" families. In contrast to the other families, narratives about "straightforward" families were empty of family or historical context or sympathy for the parents and concerned physical abuse or domestic violence about which there was a high level of certainty. The sympathetic view of neglectful mothers may also partly explain the reason for the dominance of neglect in the interview stories: there may be more motivation among GPs to respond to neglectful parents compared to parents subjecting their children to physical or sexual violence.

6.2.5.3 Inappropriate involvement from other agencies

This theme captures how the perceived role of other agencies, especially children's social care, influenced the extent to which participants took on-going responsibility for maltreatment-related concerns in the families they described. This is the third and final theme that is important for understanding the contexts in which the participants took responsibility and had on-going involvement.

In the narratives about "on the edge" and "was it, wasn't it?" families, involvement by other agencies, usually children's social care, was portrayed as inappropriate. In the descriptions of "on the edge" families, children's social care involvement was depicted as insufficient and inadequate. In contrast to the family problems, which were described as chronic, the provision of child protection services was portrayed as intermittent and inconsistent. For "on the edge" families, children's social care was viewed as both reluctant to offer services and incompetent in delivering them:

> "But I batted my head against a brick wall trying to get social services to engage with her, because I had real concerns […] but nobody has ever felt, willed or been able to do anything."
>
> *(Participant 10, GP, Family 26, 3 children 9-16y)*

In the narratives about "was it, wasn't it?" families, other services were portrayed as inappropriately heavy-handed for these families where the participant believed it very unlikely (but possible) that physical or sexual abuse had taken place:

> "Then I got a call from a doctor at...up at the child development centre to say they discussed my letter and they thought that I should refer her straight to social services, um, which was rather different from the approach that I'd wanted to take which was rather gentler because actually at the end of the day I really wasn't...I didn't have a high level of concern that C was being abused.

[…] The whole thing was rather getting...felt as though it was getting out of hand a bit."

(Participant 8, GP, Family 20, 8y old child)

"We had to make a difficult decision at that time to actually refer him into social services, um, and I think the difficulty was, with these things, they're like all or nothing responses, aren't they? They're like someone coming in with chest pain and you either decide it could be just a bit of indigestion and you give them a bit of Gaviscon or he could be having a heart attack, get a 999 ambulance. It isn't the sort of half-way house."

(Participant 5, GP, Family 14, three children 5m-3y old)

In contrast, for "stable at this point" and "straightforward" families, children's social care and secondary healthcare services were depicted as having an adequate and appropriate role with the families. For "straightforward" families, referrals to agencies were seen as triggering a set of suitable responses which could be relied on to happen automatically and seamlessly without the participant's further involvement:

"I saw a child recently with what appeared to be a new fracture and referred it, you know, kind of, do not pass go, straight to A&E, and then it moves on, you know, and then you know, that the right things have happening... happened, and in a way that kind of seems fairly straightforward."

(Participant 7, GP, family number not attributed as no other details about child)

"Well their [children's social care's] response was... was quite good and quite quick, it...[...] I made the phone call and everything happened from there..."

(Participant 12, GP, Family 30, 2 children aged 6 and 12y).

In this last example (Participant 12, Family 30) the narrative changed from "on the edge" with high involvement from the GP to a "straightforward" family where the participant relinquished responsibility and passed the case on to children's social care with no on-going involvement. This change in "taking responsibility" occurred at the point at which a children's social care referral was made and at which this agency's response was perceived to be functional by the participant. Here, trust in other agencies and their processes acted as a stimulus for handing over responsibility without longer-term involvement.

6.2.5.4 Participant feedback relevant to "why these families?"

Due to space restrictions in the leaflet, I did not seek participant feedback on the findings about "why these families?"

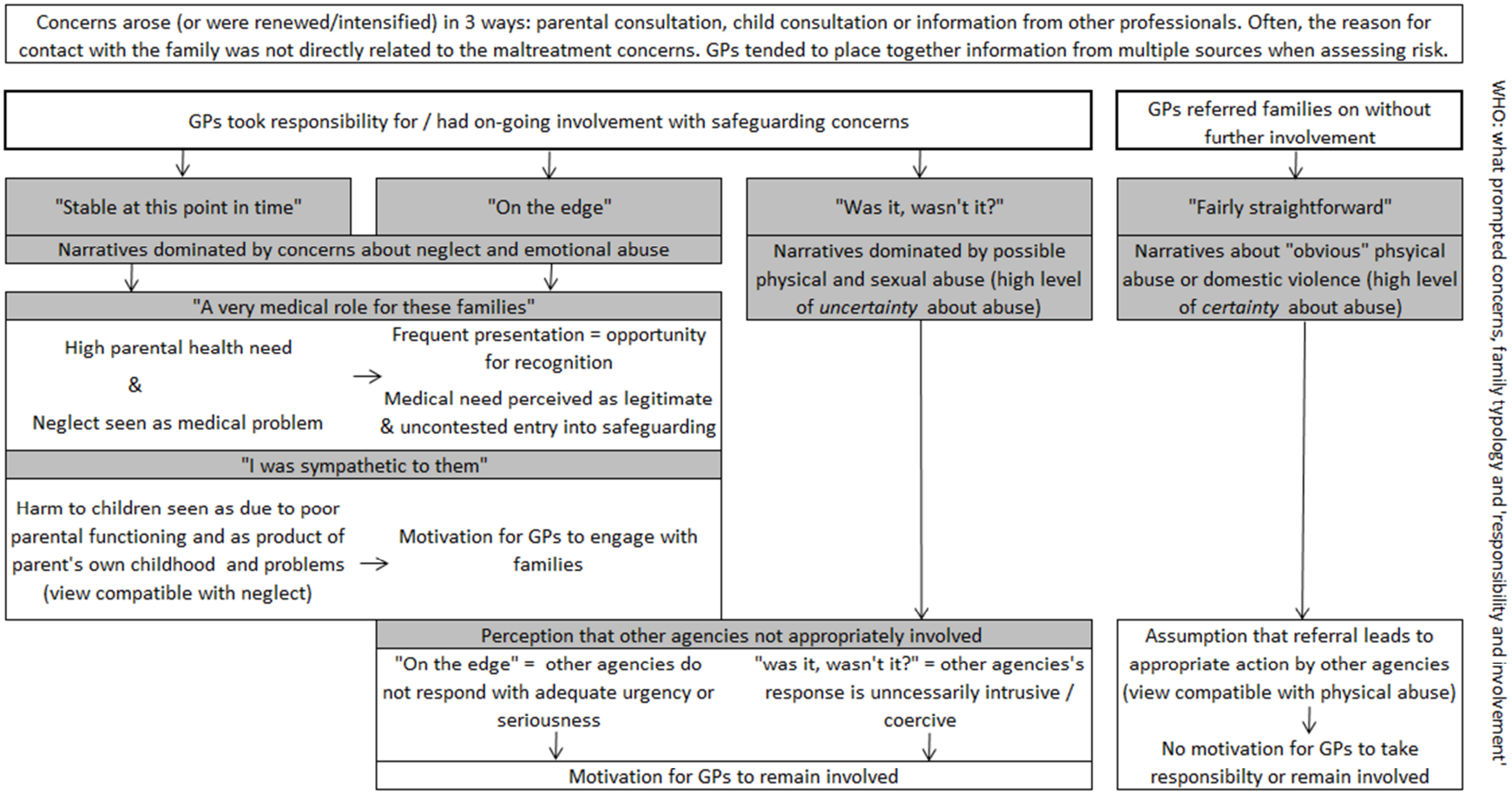
6.2.6 Key points about "who were GPs responding to?"

- There was a clear divide between "fairly straightforward" narratives in which GPs described onward referral of concerns without further involvement from themselves and the other types of families where participants described taking responsibility and having on-going involvement with maltreatment-related concerns.
- The families that GPs described were largely ones where they had taken responsibility for the maltreatment-related problems and had on-going involvement with safeguarding for the family. These tended to be ones for whom:
    - GPs framed their role and response as primarily "medical."
    - GPs viewed parents as loving but incompetent.
    - The contribution of other agencies was distrusted. Most commonly, this was a distrust of children's social care.

These characteristics seemed to be most compatible with (possibly) neglectful and/or emotionally abusive parents rather than parents suspected of physical or sexual abuse.

Figure 6-1 provides a visual summary of the findings in this section: "Who were the GPs responding to?"

Figure 6-1: Who are GPs responding to and why these families?



6.3 What actions were the GPs taking?

In the second section of the results, I present my analyses of the actions that GPs described in response to maltreatment-related concerns. This section draws exclusively on data from GP interviews.

The interview data generated seven actions which GPs described in relation to identifying and managing concerns about child abuse and neglect:

1. Monitoring concerns
2. Advocating for families
3. Coaching parents
4. Providing opportune healthcare
5. Referral to other services (social care and paediatric services)
6. Working with other services (social care and paediatric services)
7. Recording of concerns

Table 6-4 summarises each of the seven responses with associated actions and some brief context. A full description of each response is presented in Appendices 6.6 to 6.12. Recording of concerns is also covered in Chapter 7 where I discuss what my qualitative and quantitative findings tell us as a whole. See Figure 6-2 for a visual summary of how these actions relate to the typology of families and build on the themes discussed in the previous section (section 6.2.2, p. 208).

Table 6-4: Summary of responses described by GPs

Appendices 6.6 to 6.12 contain a full textual exploration of each of these actions and include participant quotations

What	For whom	How	Why	Context
1. **Monitoring:** keeping a "watchful eye" on families and being "a bit more vigilant".	Frequently "stable at this point" and occasionally "on the edge" families".	• Using routine health-checks in children and regular consultations for health problems in parents to assess well-being of children and coping/risk factors in parents. • Receiving information about family life and parenting from other family members during consultations, esp. grandmothers. • Assessing the family and risk during (routine) GP post-natal home-visits. • Checking the electronic health records for subsequent presentations to colleagues. • Interpreting missed appointments as a possible sign of escalating problems in the family. Usually this relied on the individual practitioner but one GP was developing a practice-wide system to capture all missed primary and secondary care appointments by <16s. • Using vulnerable family meetings to gather wider information, anticipate stressful or important points in a family's life, such as the birth of a new baby or to gather wider information about a family. Health visitors were essential for the meetings to fulfil a monitoring function (see section 6.4.3).	To ascertain whether or not there was relevant information that needed to be passed onto children's social care (in the form of a referral) and whether GPs should enact other strategies e.g. coaching. Missed appointments could result in a phone call from the GP and, if necessary, a letter and/or discussion in the vulnerable families meeting.	When confident that the family would seek help and disclose honest information, GPs felt comfortable with monitoring and risk assessment in "stable at this point" families. Disclosure and help-seeking behaviour in families relied on GPs role as "trusted ally" (see section 6.4.1) Some GPs and the two health visitors recognised that GP monitoring was limited due to a lack of information beyond "health". GPs relied heavily on health visitors to fulfil their monitoring role.

Table continued overleaf

Table 6 4 *Continued*: Summary of responses described by GPs

What	For whom	How	Why	Context
2. Advocating: "you've got to stand up and shout for people" (making a case to other agencies on the participant's behalf).	Frequently "on the edge", "was it, wasn't it?" and occasionally "stable at this point" families.	• Supporting requests for improved housing or benefits. • For "on the edge" families, interceding with children's social care to make this agency recognise the seriousness of the family's problems and offer what they considered to be a more appropriate level of service (usually child protection services) • For "was it, wasn't it?" families, interceding with social care to reduce an unnecessarily heavy-handed or insensitive approach and encouraging these families to demonstrate cooperation with children's social care.	Improving quality of life (housing, poverty) was perceived as directly impacting on parenting and therefore on child welfare. GPs saw many "on the edge" children as in need of protection (& sometimes removal) in order to mitigate poor child outcomes. By encouraging compliance, GPs aimed to avoid things "getting worse" and a more coercive approach from children's social care. Instead they wished to help the family access supportive services.	The need to intercede with children's social care was seen as greatest in the "on the edge" families whose children have suffered "terrible neglect" over years but where maltreatment did not pose an immediate threat to child's physical safety and/or was not as "barn door" as some of the other types of abuse.

Table continued overleaf

Table 6 4 *Continued*: Summary of responses described by GPs

What	For whom	How	Why	Context
3. Coaching: motivating and 'activating' of parents by attempting to shift mind-set, encourage parents to take responsibility for their problems and, eventually, change their behaviours.	Frequently "on the edge" families.	• Talking to parents, usually the mother, to encourage them to "look at different ways of thinking about things", such as realising "that there was actually a problem with the children" or that "stopping drinking was a good thing". • Talking to parents, usually the mother, to encourage them to "change their life" or "change her behaviours".	A parent's willingness or ability to recognise that there was a problem (in the GPs eyes) seemed to make the difference between situation perceived as hopeful and one perceived as hopeless for the family. Parental (maternal) recognition of the problem was seen as the first step in intervening to improve the child's situation.	This was described as a difficult task that was often attempted but infrequently achieved. In order to have a hope of changing parental mind-set (and eventually behaviour), GPs saw that the parents needed to be engaged with primary care and to see the GP as a "trusted ally" (see section 6.4.1)
4. Opportune healthcare: providing (missed) routine and preventive healthcare for children during consultations for other reasons.	Frequently "on the edge" families.	• Meeting preventive healthcare needs of the children during parent/child consultations for other reasons (e.g. overdue immunisations or developmental checks). • This had to be done immediately as the parents could not be relied on to come back at a later date.		Facilitated by being able to offer something that the family wanted (leverage) and easy access to a health visitor (see section 6.3)

Table continued overleaf

Table 6 4 *Continued*: Summary of responses described by GPs

What	For whom	How	Why	Context
5. Referral to other services Although there were mentions of referral to the police or to specialist child protection assessment clinics, these were rare. In contrast referral to children's social care and/or paediatric services were more common. Referral to the health visiting team is considered as part of the primary health care team and is discussed in detail in section 6.4.2.	Frequently "fairly straightforward", "was it, wasn't it?" and occasionally "stable at this point" families.	**Children's social care** • Immediately, decisively and directly following consultation with a child or parent. • After using health visitor opinion or follow-up to confirm or counter GP concerns, sometimes via an additional filter of the safeguarding lead in the practice.		Direct referrals to children's social care involved certainty about physical abuse. For emotional abuse, neglect or highly uncertain physical abuse GPs used follow-up by health visitors to scale concerns up and meet thresholds for referral to children's social care or provide reassurance and avoid referral.
	"was it, wasn't it?" families.	**Paediatric services** • Referral to hospital paediatricians for an assessment of injuries or symptoms which might be related to physical or sexual abuse. • Children referred to paediatric services were also simultaneously referred to children's social care by the GP.	GPs sought a full assessment and documentation of child injuries or symptoms, including probable cause.	GPs recounted stories of how paediatrician behaviour did not support or encourage future referrals. See section 6.4.3 for full details.

Table continued overleaf

Table 6 4 *Continued*: Summary of responses described by GPs

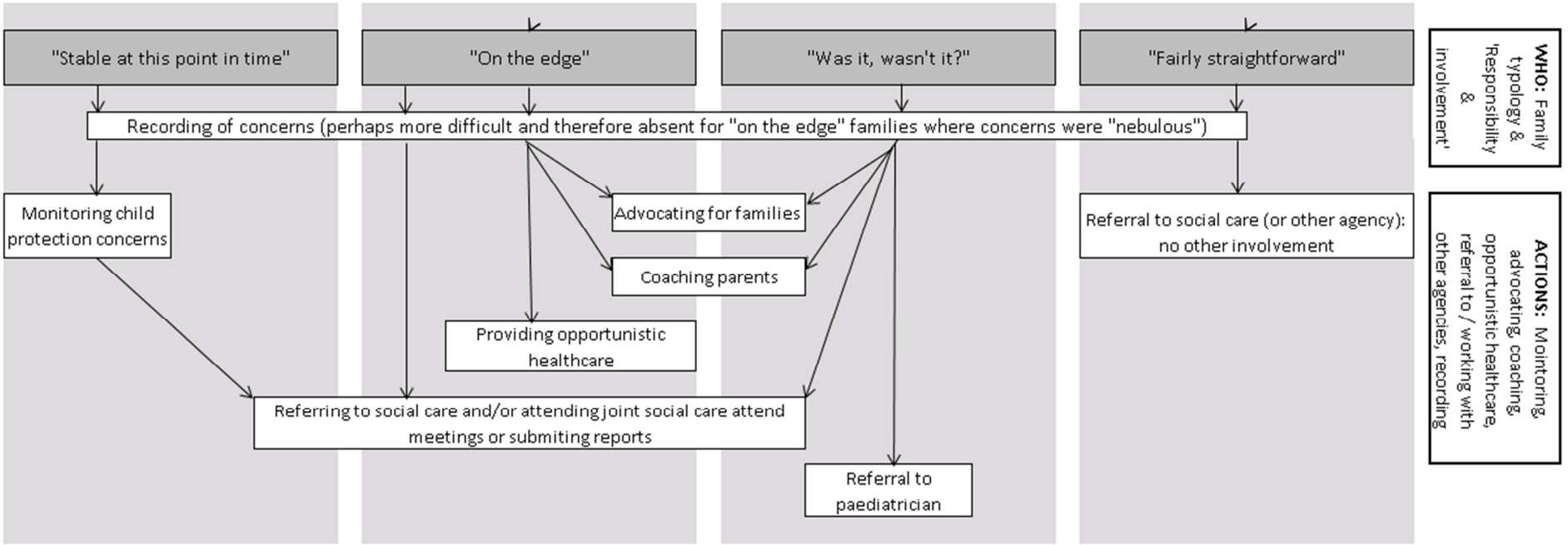
What	For whom*	How	Why	Context
6. Working with other services GPs described working with children's social care and in only one case paediatric services to which they had referred (see above).	Frequently "was it, wasn't it?" and "on the edge" families.	**Children's social care** • In only two cases did GPs describe joint working with this agency - largely through one-way communication (e.g. GPs informing children's social care about parental learning difficulties or missed appointments). • GPs relied on health visitors to act as intermediaries between GPs and children's social care, mainly via vulnerable families meetings. GPs depended on health visitors to "keep us abreast" of children involved with children's social care ad of the full content of reports and plans. • Attending child protection meetings or writing reports or using the health visitor to represent them. One GP practice allowed children's social care to hold meetings in their seminar room for free in order to increase GP attendance.		Motivation to attend joint meetings or participate in on-going joint-work occurred in the context of GPs feeling they knew the family, had a unique (often "medical") contribution to offer, had to advocate for the child to receive appropriate services or felt responsible for the family as they had made the referral.
		Paediatric services • There was only one case where a GP described working *constructively* with a paediatrician. In other cases, referral to paediatricians was seen as a necessary but disruptive response.	The GP sought a second opinion about the likelihood of sexual abuse.	The GP sought out a known and trusted paediatrician (discussed further in section 6.4.3).

Table continued overleaf

Table 6 4 *Continued*: Summary of responses described by GPs

What	For whom*	How	Why	Context
7. Recording of concerns Most of the findings about recording echoed those from the development phase of the study (see section 3.5.3). There were, however, two further themes that were new to the interview data: "The changing nature of recording" and "nebulous concerns", which are described in detail in Appendix 6.12	All families	• Variable completeness of recording (but GPs were worried and embarrassed when they had not recorded anything, saying there was "no excuse"). • Variable use of relevant Read codes, preference of recording something "vague" in favour of something specific and favouring of free-text entries over Read codes. • Higher acceptability of recording facts compared to opinions or "feelings". • Two participants felt that recording practice was changing - moving away from "vague" or euphemistic recording to more specific, structured and complete recording with increased use of Read codes. • One participant was convinced that it was most difficult to record concerns about long-term neglect and emotional abuse and that these types of concerns are particularly vulnerable to remaining "all in my head".	GPs highlighted the importance of recording for case-finding, continuity of care with other doctors in the practice and information sharing with children's social care.	There were perceived threats to the doctor patient relationship from recording (from patients seeing the records) and conflicting views about the ethics and acceptability of recording third party information in the child's records.

Figure 6-2: Who are GPs responding to, why these families and what actions are they taking?



6.3.1 Participant feedback relevant to GP actions

Feedback about the provision results from participants suggested that the seven actions were, on the whole, an acceptable and uncontroversial summary of what was happening in general practice in their eyes. The feedback suggested that the same was also true for my finding that families described as "on the edge" took most energy and time and provoked most worry. One GP strongly agreed that these families were the ones who fell below or hovered around the threshold for intervention by children's social care. Feedback indicated some controversy around the balance between GP actions that did and did not include joint working in my provisional findings: one GP commented that it was "a pity that you did not see a culture of joined up working" and a health visitor strongly disagreed that GPs *should* be responding in ways that did not include children's social care (although she agreed that this is what some GPs *were* doing).

6.3.2 Key points about GP actions

- GPs described seven main responses to concerns about abuse and neglect:
    - Monitoring.
    - Advocating.
    - Coaching.
    - Providing opportune healthcare.
    - Referring to other services (social care and paediatric services).
    - Working with other services (social care and paediatric services).
    - Recording of concerns.
- The type of action taken varied according to family type but the most and the broadest activity was seen for "on the edge" families.

- In order to improve the health and well-being of the *child*, responses were aimed at the whole family (monitoring), the parents (advocating and coaching) and/or the child themselves (opportune health care).

- There were few cases of GPs working directly with children's social care. GPs were most likely to contribute to children's social care processes or decisions when they perceived that they had a unique "medical" perspective to offer or where they thought that children's social care was not responding appropriately. The first of these factors seemed to promote ongoing joint working between GPs and children's social care. The second factor, which was far more commonly described, seemed to promote parallel and antagonistic working between GPs and children's social care with GPs perceiving themselves to be working *instead of* or *against* children's social care.

- Although GPs described referrals to paediatricians, there was an absence of *c*onstructive joint working described between GPs and this professional group.

6.4 What were the facilitators and barriers to the GPs' actions?

This section presents the detailed analysis about relationships between GPs and the families and between GPs and other professionals. Of all the themes generated from the interview data, ones about relationships were the most pervasive and were central to understanding the GP actions and the types of families to whom GPs described responding. I did not set out with a specific aim of investigating facilitators and barriers to action. Rather, from the emerging themes about relationships and joint working also came hypotheses about how relationships might help or hinder GP responses to maltreatment-related concerns, which are presented in the following section. This following section draws exclusively on data from GP interviews except where I explicitly compare the views and attitudes of different professionals.

6.4.1 The relationship between GPs and families

6.4.1.1 Developing trust

This is a key sub-theme that ran through all interviews but was particularly dominant in narratives about "on the edge" and "stable at this point in time" families. It was not present in narratives about "straightforward" families, which were typified by brevity of description and lack of detail about the relationship between participant and patient(s). "Developing trust" is related to many of the other sub-themes that are important for understanding what GPs do and why they do it. This theme should be considered a central part of the context for GPs' decisions and actions.

For participants, "trust" seemed to be a situation where parents or children viewed them as someone who genuinely had their best interests at heart, was trying to help and could be seen as an ally. The trusted ally was portrayed as someone whom families could depend on to be there and who was in control of the situation:

> "I think it's partly because I suppose they [members of this family] trust us and they know us and we are the consistent person."

(*Participant 10, GP, Family 26, 3 children 9-16y)*

"Well, I just wanted her [the mother] to know that...that although this was all very upsetting and worrying, that I kind of, um...there was someone steady and with their hand on the tiller."

(Participant 8, GP, Family 20; 8 year old)

GPs defined their position of trusted ally in direct opposition to an alternative view that patients might hold, in which the professional was seen to attack or criticise:

"rather than to persecute, punish her" (*Participant 1, GP, Family 1, 13m old child)*

"rather than […] getting at her" *(Participant 15, GP, Family 31, 2 children aged children 3 and 7y)*

"…but without feeling that we're just wagging a finger at mum" *(Participant 1, health visitor, Family 4, 2y old child)*

GPs implied that they deliberated cultivated this position of trusted ally; it was something that needed to be:

"built up" *(Participant 2, GP, Family 7, 2 children aged 2 and 3y)*

and something that they spent time "getting mum to feel" *(Participant 0, GP, Family 1, 13m old child)*

and that they "wanted [the mother] to know" *(Participant 8, GP, Family 20, 8y old child)*

There were two main ways in which GPs cultivated trust and positioned themselves as an ally offering a source of help. First, they went out of their way to make a family's life "as easy as possible" (Participant 0, Family 3). Most often this was via writing letters to support benefit or housing requests and offering this as a free service:

> Interviewer: "How do you think that family see you?
>
> Respondent: "Source of help and a source of getting things done".
>
> Interviewer: "Things like?"
>
> Respondent: Social Services. Oh, I want a two bedroom flat. I want a ground floor flat, things like that. […] They used to come for all these letters for Social Services, letters for something, housing, benefit or something or something."
>
> *(Participant 15, GP, Family 35, 2y old child)*
>
> "See, we get a lot of requests...[…] "Can you write a letter about this," "Can you write a letter about that." We...we do get a lot of that sort of stuff, um, and, you know, we're more than happy to do that. I don't usually charge for that kind of stuff, although places are fully entitled to but what's the point? They can't afford it."
>
> *(Participant 5, GP, Family 15, 4y old child with four siblings)*

The other way in which the GPs described making themselves helpful to the families was to meet their health needs:

> "Well, I think...I think they view us positively, ah, I think, I think they see us as trying to sort out some of their real medical needs."

(Participant 5, GP, Family 15, 4y old child with four siblings)

This could take the form of anticipating health needs and making extra effort to make sure that their experience of health care services was as easy as possible:

> "Nothing special, it is just getting them, making sure they have got the right meds, making sure that you hurry along the referrals, making sure that they are dealt with politely."
>
> *(Participant 0, GP, Family 3, 4y old child with two older siblings)*

Or it could take the form of making exceptions to the rules for chaotic families:

> "I'd actually said I would see her at any time on any day if she turned up at the surgery. She didn't seem to be able to use the appointment system. I would see her and I would fit her in."
>
> *(Participant 8, GP, Family 20, 8y old child)*

This last quote is also an example of the third way in which GPs positioned themselves as a trusted professional: by making themselves an accessible and consistent professional contact. During observations of a vulnerable families meeting, I learnt that in one practice a list of families that were recognised as vulnerable was kept in reception so that the receptionists knew to make extra effort to book appointments with "their" GP. Participant 10 recognised that Family 26 turned to her "at every small opportunity" because when they were "frustrated at not being able to see a social worker", they can "just ring us up and we will speak to them". Similarly, Participant 8 described extensive telephone contact with Family 20 following concerns about sexual abuse and emphasised how she made herself available to the mother in this way specifically to develop trust.

In summary, GPs sought to create a situation where they were seen as consistent, helpful and as a trusted ally. They did this by writing letters for benefit claims and housing requests, making extra effort to make their services acceptable and accessible and by attempting continuity of care (with the same GP). Due to their high health needs, help-seeking behaviour* and chaotic family life, families "on the edge" were most compatible with GPs adopting the role of helpful and trusted ally. This role was also described, though to a lesser degree, for "stable at this point" families.

My analyses raised several explanations as to why participants went to great effort to develop trust with the parents of these families. The most important of these was to encourage engagement and help-seeking behaviour in the parents. This idea ran implicitly through many interviews but was most explicitly expressed by Participant 0, who explained that she sought to develop trust in order that the mother would continue to see the GP, could ask for help if she needed it and would be receptive if the GP felt it necessary to intervene:

> "it's [the reason to develop trust] is not frightening them away because , as well, there is that kind of unseen agreement between you: 'if this gets a bit much for me, I might be asking you for a bit more help'. 'How will you be when I ask you for more help?' and I am thinking 'if this gets too much for you I might ask you if you need more help. I want you to be accepting of that help and not worried about it."
>
> *(Participant 0, GP, Family 3, 4y old child with older siblings)*

* These families were described as coming often to the GP for a wide range of medical and 'social' problems.

Keeping parents engaged with and in contact with primary care services in this way was a key motivator for the participants. Participants were keenly aware that parents and older children could choose *not* to present to general practice:

> "um, so she did come back the following week which I was kind of pleased about because I suppose you worry a little bit and basically...
>
> Interviewer: Worry about what?
>
> Respondent: ...she might be pregnant and just disappear off and these kind of things."
>
> *(Participant 6, GP, Family 15, describing 15 year old girl from a family of five who had presented asking for a pregnancy test and implied that the father was a family member)*
>
> "She hasn't been in with that child since and I suspect that she is just avoiding services."
>
> *(Participant 0, GP, Family 1, 1y old child with older sibling, explaining the consequences of her failure to develop trust with the parent)*
>
> "You don't know what's out there that isn't coming to you, that isn't choosing to come through the door, for whatever reason."
>
> *(Participant 7, GP, Family 19, 2 children aged 6 and 10y)*

They were equally aware that parents or older children could choose not to disclose information if trust was broken:

> "That girl will shut herself and she will never trust anybody and we will not be able to get all the story from her what's happening."
>
> *(Participant 15, GP, Family 36, 2 children aged 9 and 11y)*

On the whole the GPs saw the trust as something "very fragile" (Participant 0) requiring "delicate" handling (Participant 14 and Participant 15).

On the other hand, two GPs expressed the idea that, although it may "take a lot of time" (Participant 5), the relationship between the GP and the parents could be rebuilt after trust had been broken, for example due to a child protection referral:

> "I think relationships are always going to be damaged in these situations [referral to children's social care against the parent's wishes]. They're always going to be tested, but, um, there are ways to get...to get through it […].sometimes through...sometimes through adversity you build stronger relationships, don't you? There may...there may be that bit of it, I hope."
>
> *(Participant 5, GP, Family 14, three children 5m-3y old)*

> "…she was quite angry with me when it... all this was going on [referral to children's social care resulting in care proceedings]. But I think now it's... it's actually not quite as bad as it was, because I think she's... she's begun to appreciate actually that, you know, the children are being better cared for...I mean I suppose it... it's fortunate that we are still seeing her, er, and the relationship hasn't broken down completely."
>
> *(Participant 12, GP, Family 30, 2 children aged 6 and 12y)*

At the same time as emphasising the importance of trust for child safeguarding work, several participants acknowledged that they were walking a fine line between the potential benefits and harms of developing a trusting relationship with the parents. It could mean that the participant becomes blind to the possibility of abuse or neglect by the parents:

> "So I was kind of...I'm try...I'm trying to steer a line between, um, keeping her [the mother] informed [and building a relationship] and feeling I'm kind of...and not wanting to miss anything, although I really didn't think I...deep down, I thought I wasn't actually missing anything drastic."
>
> *(Participant 8, GP, Family 20; 8 year old)*

Similarly, keeping a parent's confidence (rather than refer to children's social care) was perceived to have potential implications for the safety of the child:

> "So it's a fine balance to make and sometimes as a professional you have to make sure everybody is safe and at the same time you keep that confidence."
>
> *(Participant 15, GP, Family 36, 2 children aged 9 and 11y)*

6.4.1.2 "A trade-off"

Just as many of the GPs responded to high social welfare and health needs in families in such a way as to deliberately cultivate trust, so one GP described using these same needs to create a situation where she had something to "trade" with the family. Participant 0 believed that the GP was seen as a professional who had something that the family wanted and this could act as leverage:

"….because we can actually give them what they think they want but there may be a trade-off. 'I can get what I want, if I accept this.' As a trade-off. You trade, you know. 'You do this for me and I'll do this for you.'"

(Participant 0, GP, Family 1, 13m old child)

The same participant explained how leverage gained from meeting health needs or supporting benefit claims could be used to encourage parents to accept help with parenting, to allow delivery of preventive health care for the child, such as overdue developmental checks and immunisations or to encourage further presentations which would, in turn, allow on-going monitoring of the family (see Table 6-4 , p. 231 for more information on monitoring as a response). Participant 0 was very clear that she believed the mother in her narrative was actively and consciously participating in this strategic "trading": "Oh, she *knew*" (original emphasis). Given the complicity of the trade-off, it might also be conceived of as "game-playing" between the doctor and parent: this was a comment made by one GP in their feedback on preliminary results.

Although only one GP spoke explicitly of creating leverage as part of their response to child maltreatment concerns, the "trade-off" theme ran implicitly through many interviews with GPs as they described how they went out of their way to be seen as "helpful" and as "someone who gets things done". Along with "developing trust", "a trade-off" should be considered integral to the context in which the GPs in my sample described responding to child maltreatment concerns.

6.4.1.3 "We respond to people who decide that they want our help"

The GPs' efforts to encourage help-seeking behaviour and acceptance of help (via trust and leverage) are best understood in the context of general practice as a reactive system. This was a view explicitly presented by two participants from different sites, both of whom saw this feature of general practice as a limitation for protecting children. Both participants saw how general practice could only respond to families

who asked for help, either with specific requests or by dint of coming to an appointment:

> "I think a lot of it is reactive. It's people asking us for information and us providing it, and it might be the patient wanting a letter to transport their...their...their house move or...or any number of things we write letters for, rather than us being able to say, 'I think we should be doing this, that and the other.' Don't...we don't seem to have the space to be able to think like that or act like that."
>
> *(Participant 5, GP, Family 15, 4y old child with four siblings)*

> "The way general practice is set up is, is that we respond to people who decide that they want our help. […] You know what's come to you, but you don't know what's out there that isn't coming to you, that isn't choosing to come through the door, for whatever reason."
>
> *(Participant 7, GP, Family 19, 2 children aged 6 and 10y)*

In light of this, the importance of encouraging help-seeking behaviour and help-acceptance becomes clear. As Participant 4 points out, this can *only* be done by using a relationship with the parents and relying on encouragement and disappointment for leverage:

> Interviewer: "And if she didn't – if she then hadn't done what she was supposed to have done by the time she was supposed to have done it?
>
> Respondent: I have no teeth to then in any way punish her or hold her otherwise to account. All I can say is I'm disappointed that you haven't done this. […] Doctors don't go about punishing patients by and large. We rely on our encouragement and then a sort of heavy sigh and well."

(Participant 4, GP, Family 12, 2.5y old)

The view of general practice as a responsive service explains the GPs' focus on responding to parents with help-seeking behaviour and the further encouragement of this behaviour via establishing a trusting and reciprocal relationship.

6.4.1.4 Summary of the relationship between GPs and families

Participants described how they sought to develop trust in order to maintain contact and encourage engagement. This was done with the aim of encouraging patients to "come through the door", ask if they needed help with parenting and to be receptive to unsolicited GP intervention if and when it was offered.

The relationship with *parents* was seen as a necessary facilitator for responding to *children* with concerns about abuse or neglect in the context of a system that limited GPs to being responsive. In two cases where contact with adolescents was described, the GP-adolescent relationship was seen as just as important and for the same reasons.

Developing trust was perceived to have potential harms as well as benefits and GPs described themselves as consciously navigating a course between the two. Developing trust was most possible with "on the edge" families who had chaotic lives and high health need with help-seeking behaviour and, to a lesser extent, with "stable at this point" families. The parental engagement achieved through trust was perceived to facilitate monitoring and risk assessment of the families by encouraging continued presentation to GPs, allowing GPs to get to know the families well and creating a relationship where family members volunteered information to them.

In addition, GPs perceived that the high health and social welfare need in "on the edge" families could create a "a trade-off" situation in which parental need could be used as leverage to encourage parents to accept advice and/or preventive health care for the children.

6.4.1.5 Feedback relevant to the relationship between GPs and families

Feedback from GP participants suggested that the GPs were keen for acknowledgment of their efforts to encourage vulnerable families to see general practice as a supportive service to which they could turn with troubles and from whom they might receive help. However, two participants were also very clear that relationships with parents were “uneasy partnerships” and that, in their experience, GPs “agonized over whether we challenge these patients enough”. One of these two GPs highlighted the skill needed to be able to “hold these on-going relationships […] in a really skillful way”. A return to the interview data suggested that these ideas did indeed run through the interview data and I revised the results section of this chapter to make this clearer.

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6.4.2 The relationship between GPs and health visitors

This section draws heavily on the interviews with health visitors, of which there were only two. The limited amount of data should be taken into account when reading and interpreting the views and attitudes attributed to health visitors.

In all but three interviews, GPs revealed a dependence on health visitors in their child safeguarding work and talked about this professional group far more than any other. Access to health visitor knowledge, assessments and time was seen as a necessarily facilitator of a large number of the actions that GPs described in response to concerns about child abuse and neglect. The relationship between health visitors and GPs and the way that the two professional groups viewed each other is particularly important for understanding the limitations and difficulties of GPs responses.

6.4.2.1 An unequal relationship

As Table 6-4 (p.229) shows, GPs relied on health visitors in three main ways. First, GPs relied on health visitors to know and convey wider information about a family. This was seen by GPs to facilitate monitoring of concerns. Such information was actively sought by GPs from the health visitor in order to scale concerns up/down and to decide whether or not to refer a child to children's social care. Secondly, GPs relied on health visitors to be available for weighing babies or routine health checks at short notice (to facilitate opportune healthcare). Thirdly, GPs saw heath visitors as an essential link between themselves and children's social care and relied on them for information about current or previous child in need or child protection services provided to a family. There is no doubt that the GPs in my sample viewed health visitors as an integral component of their own child safeguarding work and relied on good information exchange with them to respond to maltreatment-related concerns.

However, the two health visitors in my sample did not see GPs as key partners in child safeguarding. One health visitor was unable to answer my question about how GPs

supported her in her work with an "on the edge" family. Her hesitant and evasive answer suggests that she had not previously considered the role of the GP in her work with this family, which in turn implies that she did not see the GP as important or central. Secondly, her response implies that she did not consider herself to be receiving any type of support from GPs in her own child safeguarding role:

> Interviewer: "And how do you see, how does a GP or that GP surgery support you with what you're doing with the family?
>
> Respondent: I don't know, yeah. I, I, I mean I'll ring up and I'll say I'm worried and they'll, but yeah, I don't know really."
>
> *(Participant 2, GP, Family 7, 2 children aged 2 and 3y)*

In the two health visitors' eyes, GPs were there for "medical" problems and were not central to child maltreatment-related concerns, unless these concerns had a "medical" element:

> "Routinely if I visited a family today and identified a need for referral to Social Care, it wouldn't be on my list of things to do to phone the GP and say, I've just referred this family. Unless it was a health need as in, did I see a burn on the arm, then I might. But certainly if it was just emotional kind of neglect or anything like that, I wouldn't routinely phone the GP there and then to say I'd made the referral."
>
> *(Participant 16, health visitor, talking generally)*

The view by health visitors of physical symptoms of abuse (e.g. bruises or burns) or neglect (e.g. failure to thrive) as "medical" and therefore as GP territory was supported more generally, but more implicitly, throughout the interviews. Many of the GPs

described how cases of possible non-accidental injury or failure to thrive were referred to them by health visitors for a second opinion about possible maltreatment. However, no GP recounted an instance when a health visitor informed them of concerns that did not have obviously physical symptoms requiring medical assessment or where the health visitor had sought wider information relevant to maltreatment-related concerns from them. In the interviews, health visitors attributed GPs a peripheral, medical and forensic role in responding to maltreatment-related concerns. This means that information flow from health visitors to GPs might be only partial, something with serious implications for the completeness and effectiveness of GP monitoring, given that monitoring seemed to rely so heavily on information from and joint risk assessment with the health visitor (see Table 6-4, p.231 for a summary of monitoring).

Health visitors' view of GPs as peripheral to child safeguarding work makes sense in the context of their other perceptions about GPs. They believed GPs had much more limited knowledge than they did and were "unaware" of important information, despite having regular contact with these families:

> "I don't think they were aware, and certainly weren't aware that she was going off on drinking binges and leaving the children."
>
> *(Participant 16, health visitor, Family 31, children 3 and 7y)*
>
> "I don't think they're aware of the problems."
>
> *(Participant 1, health visitor, Family 5, 4 children under 6y)*

One health visitor explicitly stated that information flow between GPs and health visitors was only useful in one direction:

> "Certainly in my experience I've never been informed of anything that I didn't know of via a GP."

(Participant 16, health visitor, Family 31, talking generally)

In addition, both health visitors saw GPs as unwilling or unable to take on safeguarding work and as keen to off-load responsibility:

> "[The GP] just completely avoided the issue that was staring him in the face. The ideal opportunity to address it, and it was avoided. Again I don't know [why] but it is worrying and it happens more often than what I think we know, that GPs avoid addressing issues."
>
> *(Participant 16, health visitor, Family 37, 2 children: an infant and 2y old)*
>
> "I think they're, again, a family that probably take up quite a lot of the GP's time so the GP's quite happy to sort of share it out."
>
> *(Participant 1, health visitor, Family 5, 4 children under 6y)*

6.4.2.2 Relocation of health visitors

A second threat to GP responses that relied on health visitors was the relocation of health visitors away from general practice. This was cited as a barrier to good GP-health visitor relationships by health visitors and GPs alike. Two participants (Participant 2, and Participant 16) stressed the importance of informal contact between the health visitors and GPs that co-location allowed, for example at coffee breaks or in the corridor. This informal contact was seen to be essential for building a good working relationship:

> "I think ultimately being based in the same building, seeing people day to day, you know in the kitchen, putting the kettle on, that kind of daft thing does build a good relationship"

(Participant 16, health visitor, Family 31, children 3 and 7y)

It was also seen as facilitating sharing of concerns between the two professions, over and above what might be offered by electronic communication or practice meetings. This was valued so much by professionals that in one practice (Participant 2) the health visitors had been offered a quiet and well-equipped work space in the practice so that they would continue to spend time in the building.

6.4.2.3 Summary of relationship between GPs and health visitors

GPs described how they relied heavily on health visitors to support and facilitate monitoring, referral to children's social care and working with children's social care. However the working relationship between GPs and health visitors was unequal, fragile and further undermined by lack of co-location. The problematic relationship between GPs and health visitors was likely to lead to partial information flow from health visitors to GPs and marginalisation of GPs from health visitors' safeguarding work, at least in some cases. The actions and responses that GPs described as reliant on health visitor input and communication should be viewed in the context of the probably imperfect and unequal relationship between the two groups of professionals.

6.4.3 The relationship between GPs and other professionals

In comparison to their discussion of working with health visitors, the GPs gave relatively little detail about how their joint working with other professionals helped or hindered their actions. Where other professional relationships were discussed, it was in relation to children's social care and/or paediatric services. These results are presented in the following section.

6.4.3.1 Preference to be perceived as an independent agency

GPs commonly believed that both professionals and patients mistrusted children's social care and perceived this agency to have one primary role: the removal children from families:

> "But...but the association, both...both...both, I think, generally from professionals but particularly from parents is, social services means, ah, your kids could be taken off you, or, you know, you've been accused of abusing your children. I don't think there's any getting away from that association."
>
> *(Participant 5, GP, Family 14, three children 5m-3y old)*

> "I think a lot of people view social services as their only job is to take children away."
>
> *(Participant 13, GP Registrar, Family 34, unborn child)*

There was a similar opinion, though less pervasive, that patients viewed paediatricians with suspicion because of their role in establishing causation and/or their policing role:

> "She [the paediatrician] is seen as just there to check up on you."
>
> *(Participant 0, GP, Family 1, 13m old child)*

> "As soon as you mention we need to send you up to paediatrics to get this checked out they [parents] get very defensive."
>
> *(Participant 13, GP Registrar, Family 34, unborn child)*

Being seen as an ally of children's social care could, in the GPs opinion, disrupt the trusting relationship with patients which they had worked so hard to achieve and which they needed to facilitate both medical and safeguarding responses:

> "General practitioners are seen by people as being supportive and friendly and a lot of helpful things, whereas perhaps social workers are seen more as operators of the state in some way."
>
> *(Participant 4, GP, Family 12, 2 y old child)*
>
> "That can affect your relationship with the patient because then they lump you with social services and see you as part of the people trying to take away their child."
>
> *(Participant 13, GP Registrar, Family 34, unborn child)*

The desire to be seen as a separate and independent agency might partly explain the GP's use of the health visitor as intermediary and the absence of GPs working directly with children's social care in my interview data.

6.4.3.2 Other agencies don't understand the GP's needs

GP narratives indicated that neither children's social care nor paediatricians understood their professional position or needs.

Two of the GPs understood that they only had a partial picture of the situation and saw the role of children's social care as bringing together information from all agencies in order to make decisions (Participants 4 and 7). However, these and other GPs highlighted that the information flow was only one way between themselves and children's social care and that children's social care only included GPs when it suited them:

> "You don't get very much information about what's happening their [children's social care's] end you know, so it's not like if you've referred somebody to a cardiologist and you get responses about what's happening. You don't get information from social services. They don't let you know, unless there

happens to be a reason for them ringing because they want information from us."

(Participant 7, GP, Family 18, unborn child)

The one-way flow of information sharing with children's social care was seen to be exacerbated by lack of personal relationships between GPs and social workers and high staff turnover. Several GPs described how they did not know anyone in children's social care whom they could call for an update or advice or if they did have a contact, GPs had experienced staff change without warning. One GP (Participant 4) described how at the request of children's social care, and with considerable effort, they had been sending information on missed appointments for a child. The GP called social care for an update and only to discover that the social worker had left, the case had been closed and there was no need for the practice to be sending the information:

"So I then phoned social services and said, "Can I speak to this social worker?" "No, she's left and apparently although nobody has told us, the local authority and social services have dropped any interest in the case."

(Participant 4, GP, Family 13, four children 3-13y and six older siblings)

Although several narratives contained examples of GPs referring children (with suspected physical or sexual abuse) to a paediatrician for a second opinion, there were only two narratives with any detail about the *experience* of referring to paediatric services. In both these narratives, paediatricians were presented as failing to understand the delicate nature of the GP-patient relationship and the need for this relationship to be on-going in order for the GP to continue to respond to the maltreatment-related concerns:

> "They saw a general paediatrician, he just thought it was rough play and he didn't see why on earth I'd sent them along, which completely undermined our position and I...you know...you think, gosh, I'm trying to...this is a very difficult situation. It's got to be handled very sensitively even if the consultant didn't think it was anything significant. There are ways of communicating that. […] The last thing we needed was to get a secondary care response that did that because it then became more difficult to engage them at a child in need level because it's much more voluntary, isn't it? […] I think relationships are always going to be damaged in these situations. They're always going to be tested, but, um, there are ways to get...to get through it but not if...if you feel that other colleagues in the system completely undermine what you've done, which is...which is the way I felt at the time."
>
> *(Participant 5, GP, Family 14, three children 5m-3y old)*

Two other GPs (Participant 2 and 8) described how they deliberately sought out paediatricians whom they knew and trusted. For participant 8 this was done through phoning an old colleague with whom she hadn't spoken for a long time and for participant 2 this was done via the safeguarding lead in the practice:

> "He [the safeguarding lead in the practice] tells us which paediatricians to ask, whose opinions that he trusts when it comes down to child protection issues and which paediatricians he doesn't trust. So I think that would – that's – I think it's very important that as clinicians we sit and talk to each other about who we trust and who we don't trust in secondary care as well."
>
> *(Participant 2, GP, talking generally)*

6.4.3.3 Summary of relationship between GPs and other professionals

The narratives that the GPs told indicated that they wished to be seen as separate from children's social care and paediatric services. Both services were seen as insensitive to the GP's position: children's social care did not provide necessary feedback to the GP and paediatric services could unthinkingly and unnecessarily damage hard-earned patient-doctor relationships. In the case of paediatric services, GPs were able to draw on personal contacts to deliberately seek out trusted paediatricians. With lack of personal contacts and reportedly high turnover of social workers, GPs were unable to establish and then draw on similarly trusting relationships with this group of professionals.

6.4.3.4 Feedback relevant to relationship between GPs and other professionals

The one health visitor who provided feedback was extremely critical about my results. After an email and telephone discussion with her, it became clear that her comments reflected exactly the gap in expectations and perspectives between GPs and health visitors that I had identified in the interview data. In contrast to the GPs who fed back, this health visitor found the study results controversial. She was very surprised that GPs had discussed neglect and emotional abuse because, as she perceived it, GPs were "only interested in non-accidental injury". She was very hostile to the idea that GPs could be carrying out actions that did not involve children's social care (such as monitoring or coaching), citing local serious case reviews as evidence that GPs were not qualified or equipped to do much without the supervision of children's social care. She felt my results were "excusing" GP's disengagement with other professionals and joint working. The practice nurse who gave feedback did not challenge the study results. It is not possible to distinguish how far the views of the health visitor reflect that of her profession as a whole but it is worth considering the possibility that the responses that GPs see as acceptable and uncontroversial are highly contested and controversial in the eyes of other professional groups.

6.4.4 Vulnerable families meetings: an organisational level facilitator?

Fourteen of the 17 interview participants (including both practice nurses and both health visitors) spontaneously mentioned the vulnerable families meetings and did so in the context of them being “good”, “pivotal” and “important”.

Initially I conceptualised vulnerable families meetings as an “action” that was undertaken by GPs but, when analysing the results, I began to see that the participants believed the meetings to be important *facilitators* of their responses to children and families. The following sections describe the format of the meetings (section 6.4.4.1) and how the meetings did (and, in some cases, did not) facilitate GPs responses to maltreatment-related concerns (section 6.4.4.2)

6.4.4.1 Format of vulnerable families meetings

Table 6-5 shows that the meetings in each of the four practice were highly variable in their frequency, number and range of attendees, in the ‘tone’ of interaction between professionals and in the way that children and families were selected for discussion.

Table 6-5: Description of vulnerable families meetings from observations

Observation	Frequency, time, length	Purpose*	Attendees**	N families‡	Notes
Practice A (14.01.11)	Bi-monthly, lunchtime, 1h	*Stated:* strategic -to discuss policy / guidelines / systems- and to monitor specific families via information sharing. Specifically *not* for decision making. *Implicit*: To introduce professionals to one another and establish working relationships.	Healthcare assistant x2 CAMHS SW x1 Psychiatrist x1 Mental health worker x1 CP teacher x4 SENCO rep x1 Practice administrator x1 GPs x4 Practice nurse x2 NB No health visitor but she is sometimes present	1	• First meeting for many of the attendees. Many attendees did not know one another and the atmosphere was formal. • Lead Dr placed meetings in the context of other lunchtime clinical meetings – "it's nothing more out of the ordinary than what we would do for children with asthma or those with terminal conditions." • Most time spent talking about the purpose of the meetings, uncertainties about what attendees were "allowed" to discuss and the way that education / CAMHS / the practice could work together. • 'Are we allowed?' summed up the preoccupation of the meeting –great caution about confidentiality and sharing information. Each time a family was mentioned, the discussion quickly became one about confidentiality and processes (hence only one family was discussed). • No obvious selection criteria for families The SENCO representative, CAMHS social worker and 2 GPs mainly spoke.

Table continued overleaf

Table 6-5 *Continued*: Description of vulnerable families meetings from observations

Observation	Frequency, time, length	Purpose*	Attendees**	N families‡	Notes
Practice B (25.01.11)	Fortnightly, lunchtime, 30mins	*Stated:* None stated; attendees seems to share an understanding of the purpose of the meeting. *Implicit*: Monitoring and review of families (e.g. what is happening with social care, benefits, medications, children, who is living in the house) and an opportunity for questions.	Practice nurse x2 Health visitor x1 GPs x 5	13	• Participants seemed to know each other very well and were relaxed and chatty. • The meeting was proceeded by a 30 minute meeting about adult patients (e.g. new cancer patients, palliative care patients, patients who had died N=8). • The children discussed were: new births, new antenatal bookings, those on a CP plan, Children in Need, those with a "cause for concern" code in the GP records, children with cancer or children who had died. Children to discuss were identified through a computer search. • 7/13 families discussed were due to maltreatment-related concerns. • The list of children on CP plans was compared with the list that the health visitor had brought to the meeting. • Health visitor was instrumental to the meeting: she provided others with more up-to-date information, including about children's social care decisions/ services.

Table continued overleaf

Table 6-5 *Continued*: Description of vulnerable families meetings from observations

Observation	Frequency, time, length	Purpose*	Attendees**	N families‡	Notes
Practice C (01.02.11)	3 monthly lunchtime, 1h	*Stated:* to discuss and learn from/about principles rather than "get endlessly bogged down" in specific cases. *Implicit*: to enable monitoring and follow-up.	GPs x5 GP registrar x1 Health visitor x1 HV service manager x1	3	• First meeting with "new" health visitor. • Tone of meeting was extremely tentative – lots more questions than answers. • I thought that this was because there was no long standing trust between attendees but afterwards the lead GP told me (unprompted) that her colleagues had been embarrassed to admit that these were cases where the ball had been dropped because I had been there. • Implicitly, it seemed as if these children had been brought to the meeting because professionals were concerned but had lost the thread of the story e.g. there had been a case conference but GP couldn't go and wanted to know what happened. • Health visitor and her service manager were instrumental to the meeting, providing wider information including updates on children's social care processes and services.

Table continued overleaf

Table 6-5 *Continued*: Description of vulnerable families meetings from observations

Observation	Frequency, time, length	Purpose*	Attendees**	N families‡	Notes
Practice D (13.06.11)	Bi-monthly, breakfast, 45mins	*Stated:* none stated. *Implicit:* To monitor families with known concerns by exchanging information.	GPs x3 Health visitor x1 Practice manager x1	10	• Many of the GPs were away, including the GP who usually led the meeting. The practice could not find his list of vulnerable families and so had to use an "old" one. • Many of the families on the "old" list were not discussed because they had moved practice. • Only 1/10 families was discussed in depth. For the other cases it was a case of attendees saying "no, I don't have any further information about them". • Health visitor contributed but brought less information compared to other meetings. She did not know many of the children discussed.

*_Stated_=Purpose reflects that which was explicitly stated by one of the attendees at the beginning of the meeting; _Implicit_: purpose interpreted during the course of the observation and during analysis of field notes.
** CAMHS=Child and Adolescent Mental Health Services; SW= Social Worker; CP=child protection; SENCO: Special Educational Needs Coordinator
‡ Number of vulnerable families discussed at the meeting

One practice (practice B; Table 6-5) allocated an hour every fortnight to discuss problems in adults (e.g. cancer patient or palliative care patients) and, for the second half of the meeting, discussed problems in children and young people:

> "It could be anything, from a child that's constipated to a child who's got a serious medical diagnosis to a child who is a cause for concern, and we'll also discuss all the children who have child in need plans or a child protection plan."
>
> *(Participant 5, GP, Family 15, 4y old child with four siblings)*

In the observed meeting in practice B, just over half of the children and young people were discussed due to maltreatment-related concerns (N=7/13 see Table 6-5). The other three practices had meetings bimonthly (practices A and D, Table 6-5) or quarterly (practice C; Table 6-5) for 45 minutes to an hour, all of which were specifically dedicated to discussing children and young people who had prompted maltreatment-related concerns and their families. In three practices (practice B-D), GPs, health visitors and practice nurses attended the meetings, with general practice (practice D) or health visiting service managers (practice C). In practice A, there were a wider range of professionals from education and health (Table 6-5).

In two practices, the 'tone' the meeting was relaxed and chatty, seemingly on account of the meetings being well-established and all professionals knowing each other well (practices B and D; Table 6-5). In one of these practices, there was an air of efficiency with a list of patients to discuss and wider information being readily to hand whilst the other meeting appeared more disorganized. In contrast, the other two meetings were characterized by tentative and guarded interaction between professionals, seemingly on account of the professionals not all knowing each other (practices A and C; Table 6-5) and the meetings being very newly established (practice A). In one of these practice, a GP subsequently commented that the presence of the researcher had made people more cautious and self-conscious about what they said (practice C). The guarded nature of meetings appeared to be a defence against the uncertainty and 'not knowing' inherent within child protection work, which manifested itself as a

preoccupation with the thresholds of concern for information sharing (practice A) or a reluctance to admit that the professionals did not know the answers to questions being asked (practice C).

6.4.4.2 Purpose of meetings: how did they facilitate GP action?

6.4.4.2.1 Monitoring, review and follow-up

In all four practices, the meetings were seen as important for monitoring children and families. This came across implicitly in the observed meetings (Table 6-5) and more explicitly in the interviews:

> "Well, we would, um, um...I'll probably discuss it at the primary health care team meeting next week […] to those families we...you know...we always talk in our meetings They'll be discussed again, um, so I wouldn't...you know, that's the way we sort of monitor these sorts of families."
>
> *(Participant 5, GP, Family 15, 4y old child with four siblings)*

The meeting allowed GPs to monitor children and their families in three ways. First, the team could act proactively by anticipating important or stressful points in a family's life or changes which could impact on parenting (e.g. the birth of a new baby):

> "When we met regularly as a whole team, the whole practice, we were [..] recognising for example that the mother was nearing term [in her pregnancy], that the parents were complying with [methadone] treatment and all was going well. "
>
> *(Participant 14, GP, Family 34, 7 month old baby)*

Secondly, participants gathered and shared information with other professionals at the meetings, usually the health visitor, who was pivotal for supporting GPs' monitoring and review of vulnerable children and their families:

> "Of course [we ask health visitors what they know] at the child protection meetings we have on a regular basis at the practice, you might just say, "Is anyone worried about this family?"
>
> *(Participant 2, GP, Family 7, 2 children aged 2 and 3y)*

> "At meeting, we will bring that particular child up to see if there is anything new. And the health visitor will tell us if there is anything new and alert us to everything new."
>
> *(Participant 9, Practice Nurse, Family 24, 1y old child)*

Professionals turned to the meeting as a way of catching up on what had happened since their initial concern. In practice C, the cases that were brought for discussion at the meeting seemed to be ones where a professional felt that they had lost sight of the family or not managed follow-up (Table 6-5). As described in Table 6-5 in practice C the 'catch-up' function of the meeting was hindered by a reluctance to admit professional anxiety, uncertainty and incomplete knowledge around the case.

Via the meetings, health visitors were viewed as a conduit of information between children's social care and the police and general practice:

> "We found out about this [a very serious domestic violence incident] because the police alerted social services and social services obviously relayed the information to the health visitor. And in such instances where we have reports from social services, they're always brought up in our primary care team meetings so that everybody is aware of what is happening in that family at that particular time."
>
> *(Participant 9, Practice Nurse, Family 23, 2y old child)*

Thirdly, concerns by practice nurses and GPs prompted proactive information gathering via the health visitor:

> "And I brought her up at the meeting where the health visitors were present as well, […] And, again, the health visitors said they would go out and visit. And, in fact, when they got out to visit, the grandmother was also concerned that the mum, the child's mum, had been going out late at night and not coming back. And, of course, they had years and years of watching their daughter with drug use, and they thought she was using again."
>
> *(Participant 9, Practice Nurse, Family 24, 1y old child)*
>
> "But [the meeting] makes you think, and... and there have been occasions where people [health visitors] have said well perhaps I'll go around and see them again next week, just to see how they're getting on…"
>
> *(Participant 12, GP, talking generally)*

6.4.4.2.2 Risk assessment

From the GPs' and practice nurses' perspective, the main purpose of monitoring, review and follow-up was to aid risk assessment and make timely decisions about when a concern warranted being shared with children's social care. In this way, information sharing at the meeting was seen to contribute to a "bigger picture" and facilitate more accurate risk assessment:

> *Interviewer:* "How did having the vulnerable family meeting influence your view of her and...and the family?"
>
> *Respondent:* "Um, I suppose it...it concerned me more in that it was, you know, it was part of the bigger picture and... it was more, oh, right, I didn't realize all of those people were kind of in the same household. So it was helpful from a...from a bigger picture, you know, thinking about all of the children rather than just her."

(Participant 5, GP, Family 15, 4y old child with four siblings)

6.4.4.2.3 Sharing risk

One participant felt that the vulnerable family meeting allowed her to live with her decision not to refer a family to children's social care after her concern was decreased following information from a health visitor:

> "I can live with it [the risk] and actually it's shared because I have told the health visitor, I have told the other doctor and I will mention it again when I go to the practice meeting and that is as much as we can do at the moment and I don't believe she is in immediate danger."
>
> *(Participant 0, GP, Family 1, 13m old child)*

6.4.4.2.4 Encouraging inter-professional trust and inter-agency working

One practice (practice A, Table 6-5) aimed to build inter-agency trust and working between general practice, local schools and mental health care services (CAMHS; Child and Adolescent Mental Health Services). This approach was newly conceived and it was apparent it would take a long time to build these links. The attendance of professionals from outside general practice resulted in a preoccupation with confidentiality and the ethics of information sharing so that this was the primary topic of discussion and only one family was discussed.

6.4.4.2.5 Learning and peer supervision

In one meeting, (practice C, Table 6-5) the stated aim was to learn from general principles rather than support the management of individual cases. However, there was no evidence of this happening in the meeting which I observed. There was no other indication in the observation or interview data that the professionals saw the meetings as a way of learning or accessing peer supervision in this difficult area.

6.4.4.2.6 Joint decision making

In practice A (Table 6-5), the GP leading the meeting explicitly stated that the meeting were not a forum for decision making. There was no other mention of joint-decision making as a purpose of the meetings.

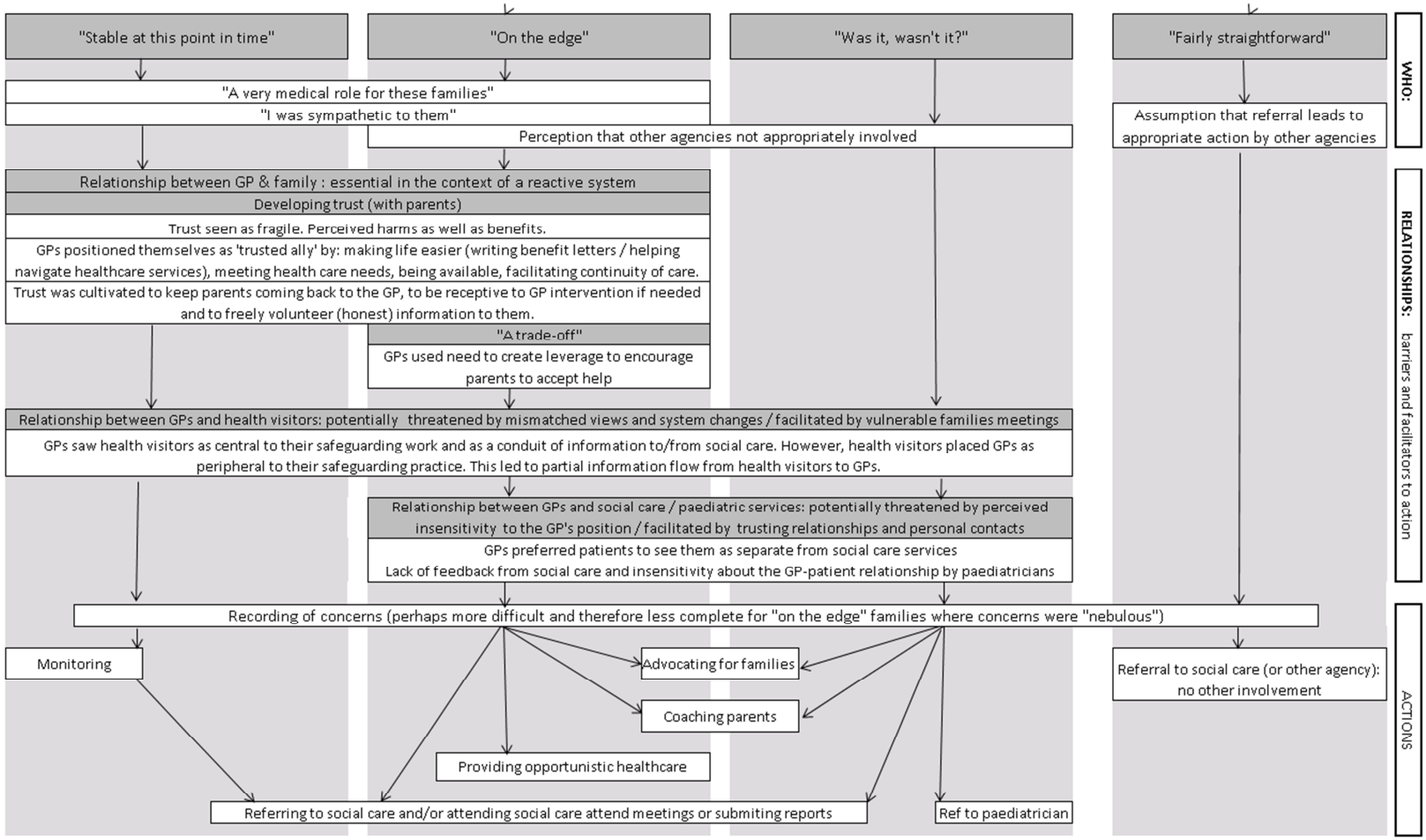
6.4.4.2.7 Summary of vulnerable family meetings

The format of the vulnerable families meeting varied greatly across four “best practice” general practice settings in England. The meetings were primarily used to facilitate monitoring of children, young people and families, aid risk assessment and support decisions about when to refer to children’s social care. There was no evidence that vulnerable family meetings were used for peer supervision and/or learning in this difficult area or to support joint decision making about how GPs and the primary care team should manage the family in their everyday contact with them. This might represent a missed opportunity.

6.4.4.3 Participant feedback relevant to vulnerable families meetings

Participants were not asked for feedback on the results relating to vulnerable families meetings or relationships with paediatric services due to space restrictions in the leaflet.

Figure 6-3: Who GPs are responding to, why these families, what actions and how do relationships help or hinder?



6.4.5 Key points about facilitators and barriers to action

- Relationships with parents and adolescents, between children's social care and patients and between GPs and children's social care and between GPs and paediatric services were seen by GPs as an extremely important context for the actions that they described.

- These relationships acted as potential facilitators or barriers to the seven GP actions.

- GPs described spending a lot of time and energy attempting to establish facilitating relationships with parents in order to create a situation where parents were likely to keep coming back, disclose relevant information and ask for/accept help. In the few cases where GPs described contact with adolescents, GPs saw relationships as important for the same reasons.

- Trust, mutual understanding and two-way information sharing was a likely facilitator of constructive joint working between GPs and other professionals (health visitors, social workers and paediatricians). This appeared difficult to achieve and was lacking from interview and observation data. Mismatched expectations between GPs and other professionals seemed to be the most significant barrier to constructive joint working. Long-standing personal relationships could be a facilitator for joint working with paediatricians.

- Meetings to discuss vulnerable children and their parents had the potential to be important facilitators of GP responses to these patients but this potential was not always realised. There are likely to be challenges to implementing these meetings in an efficient and fit-for-purpose way.

6.5 Discussion

6.5.1 Summary of findings

GPs described being actively involved with the identification and management of (possible) child maltreatment. Identification was achieved through a focus on whole families. Most GP energy and activity was focused on concerns about neglect, and to a lesser extent, emotional abuse.

- There were seven important actions that GPs took in response to maltreatment-related concerns. These actions were aimed at parents and other family members as well as children, with the aim of improving the welfare of the child. Actions were potentially facilitated or hindered by relationships with parents and/or other professionals:

    1. **Monitoring:** potentially facilitated by trusting relationships with parents or adolescents but threatened by imperfect relationships with health visitors and lack of feedback from children's social care. Vulnerable families meetings were seen as a possible way of establishing joint working with other professionals to facilitate monitoring but in practice, mutual trust and understanding seemed hard to achieve.

    2. **Advocating:** potentially facilitated by knowing the family well. Advocacy was itself seen as part of building reciprocal and trusting relationships with parents and adolescents in order to facilitate other actions, such as monitoring and coaching.

    3. **Coaching:** potentially facilitated by trusting relationships with parents and adolescents.

4. **Providing opportune healthcare:** potentially facilitated by reciprocal relationships with parents and adolescents where the GP's ability to meet the patient agenda might be used as leverage.

5. **Referring to other agencies (children's social care and paediatric services):** potentially facilitated by good relationships with health visitors.

6. **Working with other agencies (children's social care and paediatric services):** potentially facilitated by trusting relationships with other professionals, which were rarely described in practice. Potential barriers included GPs feeling as if their professional position was not understood or treated with sensitivity and a lack of personal contact with social workers.

7. **Recording concerns:** potentially threatened by concerns about ethics and confidentiality, especially in cases where concerns were on-going, lower-level and "nebulous".

GPs recognised that the deliberately cultivated relationship with parents was an uneasy one, required significant skill and had the potential to divert the focus away from the child's safety and/or needs.

Both GPs and health visitors saw the GP's role in responding to maltreatment as limited to concerns with a "medical' element" or which required a "medical" response. The GPs who were interviewed framed their responses to maltreatment-related concerns as primarily "medical" responses seemingly to legitimise their on-going involvement with maltreatment-related concerns in certain families. This might partly explain why GPs took responsibility for maltreatment-related concerns in families with high medical need and with possible neglect, which was conceptualised as a "medical" problem: GPs described how they could use a "medical ticket" to build relationships with parents and create opportunities for intervening. However, the conceptualisation of GPs as having a "medical" remit could also be used to claim that safeguarding was

“not my job”. Shared responsibility between GPs and other professionals was rarely described. GPs seemed to largely work against or instead of children’s social care. This might be partly explained by the conceptualisation of their role as “medical”.

6.5.2 Strengths and limitations

The qualitative phase of this PhD study benefited from apparently candid accounts from participants. Stories included: expressions of uncertainty about whether participants had done the right thing; examples of participants' misjudgements; and admissions that they did not have all the answers. As such, the stories in the interviews did not *obviously* serve the purpose of "image management" (portraying the participant in a beneficial or flattering light). Neither was data censored retrospectively: none of the participants asked that any of their interview data be removed, though I gave them this option.

However, given the contingent nature of any story, it is not productive to ask: did the GPs whom I interviewed actually do what they said they had done for the families they described? A more useful endeavour is, again in the words of David Silverman:

> …to understand how and where these stories were produced, which sort of stories they are and how we can put them to honest and intelligent use in theorising about the social world [or, in my case, health services]."[220]

The richness of the data (only one participant could not talk in detail about any families) allowed me to analyse the contexts of GP responses and to honestly and carefully theorise about the role of the GP in responding to maltreatment-related concerns.

The consistency of themes between the interviews and the observations suggests that there is a body of GPs who think this way. However, the small sample sizes which are a practical necessity of in-depth qualitative studies make it difficult to generalise to a wider population. Generalisability was further limited by the select nature of the participants in my study: all were working in a practice with an "expert" senior GP colleague who no doubt raised the profile of child safeguarding in the practice, instigated procedures and systems and offered more than average support and training to colleagues. It is likely that the amount and type of activity described by participants in my study might not be the norm for general practice. This view was

shared by one of the GP participants in his feedback on my preliminary results. On the other hand, my findings are very consistent with the small number of empirical research studies on GP responses to social welfare problems in both children[61 105 210 221 222] and adults,[223] at least some of which are not based on highly select populations of GPs with specialist interest. See section 6.5.3, p.279, for a more in-depth comparison of my findings with existing literature.

The results of this study provide insights into the participants' *perspectives and views*. We cannot assume that the data provide an accurate account of what the participants *did*. Nor can we assume that we have an accurate picture of presenting families and their problems. In addition, the perspectives and views were limited to those of GPs, health visitors and practice nurses. This study lacks voices from family members and other relevant professionals. I have attempted to address some of this imbalance by conducting a literature review of patient views and experiences of the GP-patient relationship which is reported in section 6.5.3, p.279 of this chapter.

Qualitative interview data are necessarily co-produced and shaped by the researcher, especially when working as a lone researcher as I was. I tried to minimize the extent of my personal influence on the results by following good practice recommendations for data collection and analysis, by using one of my supervisors to challenge my emerging themes and their connections, and by reflecting upon the probable ways in which I had shaped the data and results (see chapter 5, section 5.4, starting on p. 174 for more details of my methods). Finally, I fed back the results to participants and incorporated this feedback into the interpretation of my findings and have explicitly highlighted where this is the case.

6.5.3 Using the existing literature to contextualise findings

6.5.3.1 Who are GPs responding to?

In keeping with my findings, other qualitative studies based on English and Danish GPs consistently report that GPs focus on parents for identification of and response to social welfare concerns about children, including concerns about child abuse or

neglect.[61 105 210 222] In many cases the GP had not recently been in contact with the child.[105]

Descriptions of "on the edge" and "stable at this point families" were also compatible with other descriptions of families with social welfare problems who present to GPs.[210] Parents of "on the edge" families shared many characteristics with a wider population of adult patients with social problems (who may or may not have children).[223] The "on the edge" and "stable at this point" families are likely to represent the wider population of families who are experiencing multiple, complex and inter-related social, economic and health problems. As shown in Figure 1-2, p. 79 (Chapter 1) between 2% and 27% of children are estimated to be living in a family with this type of multiple disadvantage, depending on how it is measured. Finally, the narratives about "on the edge" and "stable at this point" families resonate with stories from an even wider population: the chronically ill. The "chaos" and "quest" story structures in Arthur Frank's theory of narrative structures in storytelling about "deep illness"* [224] overlap considerably with the "on the edge" and "stable at this point" narratives from my study.[224] In Frank's "chaos" and my "on the edge" narratives, patients share a proliferation of social and medical problems for which there is no easy answer, difficulties in navigating the health and welfare system and an inability to fulfill family responsibilities (such as parenting). The impact of both narratives is to make the listener feel overwhelmed.[224] Long-standing cases of child neglect have also been described in terms of their negative impact on social workers as well as health professionals.[81] In the overwhelmed feeling engendered in the practitioner, these "on the edge" families resonate with another type of patient familiar to the GP: the "heart-sink" patient. "Heart-sink" patients have been described as those whose chronic and multiple problems cannot be cured or solved and which elicit exasperation, defeat and helplessness from the GP.[225 226] More recently, it has been argued that "heart-sink"

* Frank's theory is an anthropological study of his own and others' "deep illness". Frank characterises "deep illness" as one that is always in the foreground for the patient and which the patient perceives as lasting, as affecting choices and altering identity.

patients usually have a history of emotional damage, ranging from the subtle to the gross.[227]

The comparison of Frank's "quest" narratives with "stable at this point in time" narratives is simpler: in both there has been, in Frank's words, a "provisional victory over chaos".[224]

When I contextualized my findings about the types of families discussed by the GPs, I drew on diverse evidence: including qualitative studies,[61 105 210 222] mixed methods studies,[223] medical anthropology,[224] case-studies[5] and opinion pieces.[226] Many of these studies have methodological characteristics that limit generalizability, including small sample size,[61 105 210 222 224 225] highly select populations of GPs,[61 105 223] poor study design,[225 228] or the fact that they are based on opinion.[226] However, when taken together, this disparate evidence convincingly suggests that "on the edge" families, specifically the parents, constitute a familiar and probably major part of GP workload, extending beyond responses to child maltreatment. The same can be said, though to a lesser degree, of "stable at this point" families.

When seen in the context of other patients presenting to primary care, maltreatment-related concerns discussed by the GPs in my sample seem to be part of a bigger group of challenging patients with multifaceted, chronic and potentially overwhelming problems.

6.5.3.2 GP actions

As described in my introductory chapter (Chapter 1), there is one other study that has explored the role of the English GP in child safeguarding: the mixed methods study by Tompsett and colleagues.[61] My findings extend Tompsett's work by providing a detailed description of the monitoring, coaching, advocating and opportune/preventive healthcare that formed part of the "case-holder" role described by Tompsett. My work also suggests that Tompsett's roles are differentially adopted according to the way that the GP sees the family "story". See Table 6-6 for a more detailed comparison of how my findings relate to the Tompsett study.

Table 6-6: GP roles in protecting children: the relationship between findings from this thesis chapter and those by Tompsett et al.

Roles outlined by Tompsett et al[61]*	Relevant findings from Chapter 6	
	Similarities	**What Chapter 6 adds**
1. The case holder: GP has on-going relationship with family before, during and after referral to children's social care. This role builds on voluntary disclosure and establishing trust over time with the parents. This role was clearly identified by GPs but not recognised so much by the stakeholders.	Comparable to the role that GPs in my sample described in relation to "stable at this point", "on the edge" and "was it, wasn't it?" families, both in the on-going nature of the relationship with families and in the reliance on voluntary disclosure and trust by parents. This was the most commonly described role by the GPs in my sample.	This role was most commonly adopted where: • Families had multiple health problems which: o Provided a reason for repeated contact. o Legitimised GP intervention in child maltreatment-related concerns. o Offered opportunity for establish trust and reciprocity and encourage help-seeking behaviours by meeting high need. • GPs thought children's social care was either not involved enough or was being too heavy handed. • GPs could construct concerns as due to "incompetent" (rather than "malicious" parenting) which allowed sympathy with the parents and facilitated on-going GP involvement. • These factors were typical of families who prompted concerns about chronic *neglect.* In my study, the role included monitoring, coaching, advocating and opportune preventive healthcare.

Table continued overleaf

Table 6-6 *Continued*: GP roles in protecting children: the relationship between findings from this thesis chapter and those by Tompsett et al.

Roles outlined by Tompsett et al[61]*	Relevant findings from Chapter	
	Similarities	**What Chapter 6 adds**
2. The sentinel: GP identifies child maltreatment and refers the concern to children's social care or other health services.	Comparable to the role for families with "fairly straightforward" concerns (infrequently described) for whom concerns were referred onwards with no further involvement.	This role might be performed most commonly where: • GPs perceived that other agencies responded (or would respond) appropriately. This was typically in cases of concerns about *physical abuse* or, less frequently, an episode of acute neglect.
3. The gatekeeper: GP provides information to other agencies so that those agencies can make decisions about access to services.	This role was not directly comparable to any described by the GPs in my sample.	The GPs did offer information to children's social care, especially for "stable at this point" families. However, this information was unprompted and resulted from on-going monitoring and risk assessment for families with a history of very serious child-maltreatment concerns who had achieved a fragile stability.

Table continued overleaf

Table 6-6 *Continued*: GP roles in protecting children: the relationship between findings from this thesis chapter and those by Tompsett et al.

Roles outlined by Tompsett et al[61]*	Relevant findings from Chapter	
	Similarities	**What Chapter 6 adds**
4. Multi-agency team player: GP has continued engagement with other professionals outside the practice. This role is fulfilled when GP contributes actively to social care child protection processes.	Comparable to the few instances in which GPs described working with children's social care and actively participating in their child protection processes.	This role might be performed most commonly where: • GPs knew the families well and did not trust children's social care to offer appropriate services • GPs perceive that there were medical issues giving them a unique medical perspective.

* The study by Tompsett et all was a mixed methods study aiming to explore the nature and consequences of conflicts of interests for English GPs in safeguarding children, though the scope of the findings were much broader. The study consisted of: a literature review of research and policy on the role of the GP in safeguarding children; a survey of 96 English GPs, in-depth interviews with a subset of these GPs (N=14); interviews with key stakeholders (professionals operating a strategic level in two Primary Care Trusts PCTs and the relevant Local Safeguarding Children's Board (N=19); focus groups with young people (N=1), young mothers (N=1) and a minority ethnic group (N=1); and a Delphi consensus about the guiding principles of GPs in safeguarding children (with 25 experts). Data was collected between 2006 and 2008.

Like my study, the Tompsett et al. study suggests that GPs might have the biggest role to play for children with chronic neglect, that health visitors are a key professional in GP's safeguarding responses, and that building rapport with parents and providing follow-up and careful recording are good practice strategies in this area.[61] The study by Tompsett et al. and other qualitative studies also report that GP responses to social welfare concerns in children, including concerns about child abuse or neglect, are often aimed at parents.[61 105 210 222]

Just as the narratives about families in the interviews resonate with other narratives about/from GP patients, so the seven responses I identified are common strategies employed by GPs in their wider practice. In the following paragraphs I describe how this is the case for each of the seven actions I identified:

Monitoring: monitoring, which can also been termed review or "watchful waiting", is a substantial part of GP practice and has been used as part of proactive management for other groups who present with a mixture of social and welfare problems, such as the frail elderly.[229]

Some of the strategies that the GPs in my sample described using to monitor families with maltreatment-related concerns have been described by GPs elsewhere both in relation to maltreatment and to a wider group of "deprived" patients". A Dutch study which conducted focus groups with public health nurses and public child health physicians in 2009-2010 reported that monitoring of concerns about maltreatment in children was enacted through home-visits, inviting the family back to clinic, discussion with colleagues (including at team meetings) and investing in building relationships with families.[221] These same techniques for monitoring were described by the GPs in my sample (see Table 6-1, p. 207 for details). Additionally, a group of GPs working in the 100 most deprived practices in Scotland[5] ("GPs at the Deep End") had previously articulated my finding that monitoring of maltreatment-related concerns in children

[5] http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/)

can be enacted through contact with other family members, with whom it is necessary to build a relationship so that the GP can elicit relevant information:

> Sometimes the only way to monitor a child is when Granny comes to see the GP about her own health need.[230 p.5]

The centrality of the doctor-patient relationship for monitoring is also supported by a qualitative study of vulnerable young people which reported that trust was a key facilitator for disclosure of abuse or neglect and that this trust had to be built by individual professionals.[25]

However, if GPs are relying on information gained in consultations from family members, they may well be basing their risk assessment on imperfect or impartial information. Research about domestic violence highlights the large proportion of problems not known to GPs. In a Norwegian study, almost 6% of adult patients attending a GP surgery said that they had experienced violence or threats from someone close but only 19% of these were known about by the GP.[231] In another English study, only 17% of women who said they had experienced domestic violence had this recorded on their primary healthcare record,[110] though we know from my in-depth interviews and workshop that GPs often know about concerns and do not record them. Imperfect information may lead to inaccurate risk assessment for the child and family. In addition, monitoring can be perceived by parents as threatening surveillance and may discourage use of services.[57]

Advocating: acting as an advocate to help patients access and navigate services within and beyond the NHS is an accepted part of managing chronic health conditions.[232] There is evidence from qualitative studies that patients with high social and health need desire and/or expect their GP to fulfill this advocacy role.[233 234] Advocacy (as I define it in Table 6-4) shares some characteristics with "social prescribing" which has been seen as a way of encouraging holistic responses in general practice:

> Many GPs develop some knowledge about resources outside of the health service that can assist patients; for example, with financial problems, domestic

> violence, or housing issues. Some GP practices also work with outside groups to promote or plan local resources. This practice of signposting patients to non-health service resources has been labelled "social prescribing".[235 p.350]

The Deep End GPs have emphasised that social prescribing does not just involve onwards referral but also relies on "experience and empathetic relationships to support patients to make use of the most appropriate resources at the right time."[235 p.350] This is a characteristic shared with the "advocacy" role that I identified in my data.

Coaching: coaching shares features with "holding" relationships, which have been identified as a strategy that GPs use to manage patients with chronic conditions[236] and the only other empirical study about GP safeguarding in England (by Tompsett et al.)[61] identified "case-holding" as one role that the GP could play. GPs have identified holding as a small but routine part of their work.[236] Holding relationships are defined as establishing and maintaining a trusting reliable and constant doctor-patient relationship without expectation of cure. They can offer stable support to emotionally needy patients and can encourage patients to develop an active role in their health. These relationships are perceived by patients and doctors to facilitate disclosure of hardship (such as domestic violence or past abuse) and to help patients cope with these issues.[236] The concept of coaching incorporates elements of Balint's famous idea of the doctor-patient relationship as potentially therapeutic, summarized in the expression: "doctor as drug".[237] The potential harms of holding relationships and doctor as drug have been described as patient dependency on the doctor, tolerance of "bad" behaviour and missing new and serious symptoms.[236 238]

Coaching also incorporates elements common to "self-management" of chronic disease and "motivational interviewing", in which professionals attempt to activate patients by encouraging them to take responsibility for their own health. The Deep End GPs describe motivational interviewing as a way of "chipping away" at the problems which prevent patients taking responsibility for their health and which act as barriers to behaviour change.[239] In my study GPs coached parents to take responsibility for the impact of their behaviour on their parenting capacity and/or children. There is some

suggestion from wider literature that helping parents to see that their behavior or situation is problematic and understand its impact on the children, as the GPs in my sample described doing via coaching, might encourage help-seeking behavior: in a qualitative study with 14 women living with domestic violence (of whom six had children) two key barriers to help seeking with family doctors was a denial that a) there was a problem or b) that it impacted on the children.[240]

In addition, coaching has already been identified as a promising intervention for children with common mental health problems in general practice settings in England: a pilot study of enhanced GP services for this group included "psychological counselling" by GPs which aimed to help children understand their own problem and become ready for change.[241] The study concluded that this type of enhanced service was feasible for GPs (with support and sufficient time) and was welcomed by the young people. However the study did not measure the impact of outcomes on children and young people or on general practice as a service.

Coaching might be a promising response to maltreatment-related concerns, especially in neglecting families. Previous studies have argued that parental belief about being able to take control of their lives and affect change was a key difference between neglectful and adequate parents.[242] This argument supports attempts to activate parents and shift the locus of control as part of a response to concerns about neglect. As described in Chapter 1 (section 1.6.2, p. 69), motivational interviewing has been viewed as a sufficiently promising approach to be used as a component of interventions to prevent child maltreatment in American paediatric primary care settings and to respond to domestic violence in English and Australian general practice. It is not at all clear from these trials whether motivational interviewing improves outcomes for children and families (see Chapter 1, section 1.6.2, p.69 for more details).

Results from a systematic review of the effectiveness of interventions for domestic violence in general practice suggested that coaching could be effective for women living with domestic violence: the authors of this study concluded that "advocacy" could reduce abuse and improve women-centred outcomes such as social support and

quality of life. [243] The concepts of "advocacy" were similar in this study and my study (as I describe in my results section, Table 6-4, p. 231). However, in the systematic review, "advocacy" was also very similar to my concept of "coaching".[243] We do not know whether such an intervention aimed at parents would also improve child outcomes.

Achieving attitude or behaviour change in patients through coaching was described by GPs as "one of the most difficult aspect of practice" in one qualitative study.[244] Like the GPs in my sample, the Deep End GPs[239] saw coaching (or motivational interviewing) as "chipping away" rather than an action that could affect large and sudden change in behaviour. GPs in England participating in another qualitative study felt that attempting to coach a patient outside of a sufficiently robust relationship could cause the patient to feel affronted, resulting in that patient disengaging from services and effectively being "lost" to general practice.[27] This was a sentiment shared by the some of the GPs in my sample.

There is little available evidence about how acceptable coaching might be to families who prompt maltreatment-related concerns in general practice but we should not assume that it is acceptable to the patients in question: one qualitative study of 36 women who had recently disclosed domestic violence to a family doctor in the Netherlands reported that only 2 wanted "a solution" from their doctor.[245] The remaining 34 women wanted an empathetic approach in which the doctor listened kindly and attentively to her story, showed concern and compassion, acknowledged the abuse and provided emotional support. [245] If coaching were seen as unwanted attempts at offering a "solution", it may well offend or annoy patients and stop them seeing help from general practice in the future.

In summary, although coaching has already been identified as a promising intervention for children and women with abuse and neglect in primary care settings, the evidence about its benefit for children who prompt maltreatment-related concerns in English general practice is far from conclusive and we cannot assume that it is without harm.

Opportune healthcare: providing opportune healthcare as a routine part of consultations has been long considered a fundamental part of the GP consultation.[246]

Referring to other services and joint working: GPs have to make referrals to and work with social care for a range of populations, including the elderly and patients with serious mental health problems. The role of the health visitor, however, is specific to working with children's social care in the context of child health in the under-fives (the population with whom English health visitors work). Although the absence of co-location was identified as a barrier to joint working with health visitors in my study, there is evidence from qualitative studies of child protection team working that co-location is "not a magic wand" for ensuring seamless communication and information sharing between professionals.[247] [248]

6.5.4 Relationships: barriers and facilitators

6.5.4.1 Using medical framing to legitimise responses

In my study, framing responses to maltreatment-related concerns as medical or as a normal part of the GPs role were ways of legitimising GP responses to child maltreatment-related concerns. This echoes comments from another English study in which GPs stated they tried to keep responses to child maltreatment within a "medical model" and believed that other agencies did not understand that everything else was "outside our remit".[61]

The tension between legitimate "medical" responses to maltreatment-related concerns and contested "other" responses can be usefully understood in the context of a wider conflict within primary care: that between the "Lifeworld" and the "System", as defined by the sociologist and philosopher Jürgen Habermas.

Here, it is worth taking a moment to outline Habemas's theory of Communicative Action, as applied to healthcare settings. Habermas posited a struggle between two types of rationality ("Purposive" and "Value" rationality) which create two worlds: Lifeworld and System, respectively.[249] Lifeworld consists of the patient's grounded and

experiential world, occupied by friends, family and home life while the System is the external context of institutions, economy and political power, into which category medicine and biomedical discourse fall.[234 250 249] Within the System, actions and communications are orientated to success (i.e. getting what either the patient or the doctor wants, termed "strategic action") whereas in the Lifeworld, actions and communications are orientated towards understanding (i.e. renegotiating parameters to achieve a collaborative solution, termed "communicative action").[234 249] Habermas perceived that the Lifeworld was under threat from the System and that balance could be redressed through communicative rather than strategic action which would facilitate mutual understanding in the absence of coercion or the use of power.[249]

The conflict between Lifeworld and the System has been identified as a fundamental component of GP-patient consultations, with GPs being seen to work within a largely biomedical model which can come at the expense of the Lifeworld,[234 251] though the two worlds and attendant discourses have also been observed to coexist in consultations.[249]

When responding to concerns about abuse and neglect, the GPs in my sample appeared to embrace the Lifeworld, especially for "on the edge" and "was it, wasn't it?" families and to approach communication with the families in terms of Purposive Rationality. They sought to place parenting and child welfare in the context of the family's lived experience and the mother's own childhood experiences; they deliberately fostered a relationship that encouraged patients to come to them and discuss the wider context of their home-life. However, the GPs also conveyed a sense that participating in the Lifeworld was an uncomfortable and contested role for their profession and they perceived that their official or legitimate remit lay within a biomedical (System) model. Stepping outside the System was seen as sometimes inevitable in response to concerns to child abuse and neglect but left them in unchartered waters and open to professional challenge. The healthcare needs of certain families gave GPs not only opportunity but *permission* to respond to social problems. This view of the GP role as bounded within the System was clearly voiced by the two health visitors in my sample and is reflected in studies that report that GPs

find it easier to respond to the medical (psychological) sequelae of social problems than the social problems themselves.[223] Although guidance from NICE is clear that doctors have a role to play in identifying and managing patient's social problems,[128 252-255] the tension between a legitimate medical role and a contested Lifeworld role is not even hinted at, let alone openly discussed in the guidance.

GPs responses to maltreatment-related concerns are likely to reflect that which normative beliefs and discourses give them permission to do. Currently, this may encourage GP involvement in some types of families but not others and/or allow professionals to individually define what constitutes "my/their job".

6.5.4.2 Trust

The GPs in my study identified parent (and adolescent)-GP trust as an important facilitator of their responses to concerns about abuse and neglect in children. This echoes findings of two previous studies of GP responses to social welfare problems in children[105] and adults.[223] The authors of a systematic review about identifying and responding to domestic violence in general practice concluded that the positive impact of "advocacy" was greatest for a subset of women *who had actively sought help*.[243*] This finding resonates with the views of the GPs in my sample who sought to encourage help-seeking behaviour in parents by establishing a trusting relationship. Another study using focus groups with 34 parents in England reported that parents shared this view: participants reported that they were more likely to seek help for emotional and behavioural problems in their children when they experienced their GP as empathetic, concerned and helpful.[179]

The trust that the GPs in my sample described was largely what Robb and Greenhalgh would call "coercive" and only sometimes was it "voluntary".[256] Coercive trust occurs when one person effectively has no choice but to trust the other in the context of unequal power and/or knowledge, such as when the GPs in my sample deliberately

[*] In this systematic review "advocacy" included linking women to support services such as housing and shelters and also empowering them through counselling and support.

used their position as gatekeepers of medical care and powerful advocates for benefits and housing services to deliberately construct a professional persona of trusted ally. Voluntary trust is genuine and mutual and tends to be built up iteratively over time.

My data support Robb and Greenhalgh's findings that communicative action was allied with voluntary trust and strategic action with coercive trust.[256] The themes of "trust", "trade-off", "opportune healthcare" and "coaching" are united by an underlying element of strategic action: the GPs entered into certain types of relationships with the patients in order to maximize the chances of improving the child's well-being. Strong reported a similar finding in his seminal text on doctor-parent-child interaction in consultations and concluded that this was particular to the context of child health where there is increased doctor responsibility without an equal measure of power:

> "By and large staff cannot force parents to do this or stop doing that: they can merely suggest or imply […] The universal idealization of parents' good character and the great lengths to which doctors went to maintain this might not be so strenuously followed in other medical settings. I do not mean by this that investigative character-work [uncovering a person's moral essence] with adult patients is likely to be common, merely that the doctors' greater responsibility for child patients, when coupled with their lack of power is likely to have made them especially nice to parents, since they had few other resources on which to draw if they wished to bend parents to their will."[257 p.20]

The way that the GPs in my sample talked about "trust" shares many characteristics with the ways that social workers answered the question "How do you know the difference between a client [involved in compulsory child protection procedures] who is just going through the motions and one who is positively involved in a helping process?", as reported in an American study by Yatchmenoff and colleagues.[258] In this study, social workers described how they encouraged and assessed receptivity (openness to receiving help), expectancy (a sense of being helped), investment (active participation, including help-seeking) and a working relationship (relationship with worker characterised by sense of reciprocity and trust). The social workers also

assessed mistrust, defined as a belief that the agency or worker was manipulative or had intent to harm the client. The high level of overlap between the discourse in my interviews and in the Yatchmenoff study suggests that responses by GPs and social workers may share some of the same characteristics. Further work in this area should systematically review the social work literature on client engagement for relevancy to GPs, as well as reviewing what is already known about engaging patients in heathcare settings. Such a systematic review is beyond the scope of this thesis.

Although trust between doctor and patient can influence health-related behaviour, including compliance with advice or treatment and attendance at appointments,[256] we cannot assume that a trusting doctor-patient relationship is always beneficial in the context of responding to concerns about child maltreatment. First, although *coercive* trust may be appropriate in the context of concerns about child abuse or neglect where parents cannot be assumed to be benign, it is plausible that it might be unacceptable to patients and in fact, works against the outcomes it is designed to achieve. This may be particularly the case for parents who already have hostile attitudes to state power following, for example, coercive child protection procedures. It may also be that coercive trust prompts disguised compliance from parents, which can be dangerous as it reduces professional anxiety about a child without changing the child's situation.[81]

Secondly, there is a danger that trust becomes an "accommodative strategy"[257] towards the parent that ends up affirming patterns of the "bad" behaviour[238] and which encourages professions to focus on parents and overlook the needs of children, resulting in inadequately protecting them from abuse or neglect. This was something that was recognised by the GPs in my sample. On the other hand, developing a trusting relationship with parents can also be seen as a "containment" strategy, which has been put forward as an appropriate approach within social work for keeping children safe.[259] In the context of professional practice, "containment" is achieved when the quality of the relationship between practitioner and client allows parents to feel recognised, acknowledged and safe.[259] It has been argued that "contained" parents pose less risk to the child because they can be helped to keep the child "in mind"

(mentalising their children's psychological condition and understanding their child's behaviour and needs).[259] Helping parents to keep the child in mind was the aim of coaching parents, as explained to me by GPs in the interviews. So, although there is a danger that developing a relationship with the parents might endanger the child, there is also a basis for using the GP-parent relationship to protect the child and promote their welfare. As Brigid Daniel argues in her review of the evidence about professional responses to child neglect, relationships between parents and professionals need to be supportive yet challenging.[19 (p.141)]

Although trust and communicative action are generally seen as facilitating humane and effective healthcare, we should question how far voluntary trust and communicative action are feasible or effective for parents who prompt child maltreatment-related concerns. It is widely acknowledged that the core features of a therapeutic relationship are warmth, empathy and genuineness.[259] These characteristics might not be compatible with the "trade-off" approach adopted by some GPs in my sample (this theme was described in full in section 6.4.1.2, p. 247). A "trade-off" approach might be more compatible with coercive trust and strategic action and we cannot assume that this type of trust has the same therapeutic benefits attributed to voluntary trust. The nature of the GP-parent relationship needs to be evaluated in the context of maltreatment-related concerns in terms of its impact on outcomes for the child and parents. However, therapeutic relationships are notoriously difficult to measure and evaluate.[119]

My data clearly suggested that inter-professional trust was likely to be a facilitator of joint working which, in turn, might allow information sharing for risk assessment and monitoring of families. This is not a new idea: other studies have reported that a collegiate team environment is perceived to be essential for effective team work in child protection[260] and, as in my study, constructive joint working has previously been described as dependent on informal communication and personal relationships.[261] The perceived implications of high turn-over of children's social care staff for joint working have also been noted in other studies, as have the mismatched expectations of roles between different professional groups working in child protection.[262] As highlighted in

my observations of vulnerable families meetings, GPs are engaged in multidisciplinary team working in other contexts, including palliative care, the frail elderly and/or vulnerable adults. Future research should draw on the large literature on multidisciplinary working between GPs, social care and secondary care services in these areas in order to generate hypotheses about creating a collegiate team environment and/or maximizing the usefulness of the vulnerable families meetings.

6.5.4.3 Parent, young person, adolescent and child view of the doctor-patient relationship in general practice: literature review

To explore how far parents, young people, adolescents and children experienced the doctor patient relationship as empathetic, trusting and reciprocal (i.e. in the way that the GPs in my sample aimed that they should), I reviewed relevant literature reporting patient perspectives (rational and methods for review described in Chapter 5, section 5.4.11, p. 196).

I found 14 relevant studies which met my inclusion criteria (detailed in Appendix 5.6) which provide a picture of highly variable views and experiences of the doctor-patient relationship in general practice in the UK. I also located seven relevant literature reviews which were used to contextualise my findings and are described in Appendix 6.13.

As Table 6-7 summarises, nine studies reported views and experiences of GPs as a professional whom participants could turn to, who welcomed them and whose advice could be trusted.[25 179 263-267] Three studies also reported views and experiences of GPs as empathetic, good listeners and not rushing patients.[61 179 264]

Table 6-7: Summary of positive and negative views and experiences of GPs

For full citations of the 14 included studies see Appendix 6.13

				Positive							Negative						
			Parents (P), young people 13y+ (YP) or children <13y (C)	Can turn to / feel welcomed/ I trust the GP's advice	Positive experience (no futher details)	Feel reassured	Feel listened to / GP empathetic	Don't feel rushed	GP facilitates access to secondary care / other services		Too much emphasis on prescribing	GP dismissive / feel not listened to / feel not believed	Unhelpful / negative experience (no further details)	GP is patronising / feel judged	Feel rushed / as if GP wants to get rid of me	GP's remit is narrowly 'medical' (or 'physical')	Quality / experience of general practice depends on GP**
Qualitative	Vulnerable population	Boddy 2012	P &YP						X			X					
		Cameron 2007	YP	X							X	X	X		X		X
		Chase 2008	C&YP		X		X		X		X						X
		Cossar 2013	C&YP	X												X	
		Sayal 2010	P	X			X	X				X			X	X	X
		Tompsett 2010	P &YP			X	X	X			X	X	X		X		X
Survey*	Vulnerable population	Healthwatch 2013	YP											X			
Qualitative	General population	Children North East 2011	YP								X	X		X			
		French 2012 (ind. a survey)	YP	X		X	X	X	X		X			X	X	X	X
		Woodman unpublished	YP	X								X	X	X			
Surveys*		Action for Children 2013	P	X													
		Balding and Regis 2012	C&YP	X									X				
		NCB 2012	C&YP	X										X			
		Well-centre unpublished	YP	X													
Count of studies				9	1	2	4	3	3		5	6	4	5	4	3	5

*Questionnaire using closed questions

*Based on conclusions of/inferences from study as well as comments by individual study participants.

However, as Table 6-7 also shows, 12 studies also reported negative views and experiences. Many of these negative views were diametrically opposed to the positive accounts: participants felt that GPs didn't listen to them, were dismissive, didn't believe or take them seriously, patronised or judged them, had a narrowly 'medical' remit and were too focussed on prescribing.[25 61 179 263 264 266-271]

There was no obvious difference between the views and experiences reported by studies based on vulnerable populations and those based on the general population (see Table 6-7). Due to difficulties in accessing adult-orientated services and talking confidently with professionals,[272] children and young people may share some characteristics with vulnerable populations. As all but one[265] of the studies sampled from the general population were based primarily on young people, this may explain why similar views and experiences were reported by 'general' and 'vulnerable' populations. In support of this hypothesis, the two studies reporting solely positive views and experiences of GPs were based on parents from the general population[265] and young people who had received specialist youth-orientated GP services (Well-Centre; Table 6-7). However, both these studies used highly structured questionnaires which, as Table 6-7 shows, generated a far narrower range of views and experiences than studies allowing participants to speak discursively about their views and experiences (in interviews and focus groups).

Contrasting views were reported by different participants in the same studies (Table 6-7) and also by the same participants about different GPs. One study which included participants registered at the same two practices reported that accounts of specific GPs were consistently positive or consistently negative across participants.[61] This suggests that the polarised views and experiences are driven by variation between GPs and their professional practice as well as vagaries of interactions between GPs and patients and differing GP and patient expectations.

Although there was high variability in views and experiences of GPs as reported by parents, young people and children in the studies, this might be a familiar pattern across all professional helping services. A literature review of adolescent views of

'helping' professionals concluded that teenagers found it difficult to talk to *all* professionals.[272] Some of the same criticisms and compliments were made about health visitors[179] and social workers[268 269] as of GPs in the included studies (see Appendix 6.13 for full details). In the other relevant literature reviews that I identified, there were mixed accounts of *all* health professionals by children and young people. Many were criticised as judgemental, not listening, unavailable, uninterested and not treating them as an individual, though the picture was not universally poor (for full details of these reviews see Appendix 6.13).

In the context of views and experiences of other health professionals, GPs do not seem to be any worse at engaging and forming relationships with children, young people and parents than other helping health professionals and, perhaps might be better at doing so than some professionals from other agencies. Indeed, in one study, GPs were nominated as the second most helpful service by care-leavers (after one-stop shops and housing projects).[263]

Together, the 14 studies that I found suggested that some parents, young people and children saw the GP as having a one dimensional or narrowly medical remit. This took two forms: either participants believed that GPs were only there to attend to "physical" problems rather than emotional distress,[25 179] or participants felt that GPs *should* help them with emotional problems but that GPs did not share this holistic view and had their own "medical" agenda.[61 264 269 271] The perceived role of the GP as narrowly "medical" appeared to explain why GPs were very infrequently mentioned (compared to other professionals such as teachers) in 261 online forum threads about abuse and neglect.[25] In four studies that did not meet my inclusion criteria and were not included in the review, vulnerable young people did not appear to value, recognise or have experienced GPs as a source of help for emotional distress or mental disorders.[65 273-275] In three of these studies, vulnerable young people did not mention GPs (or doctors) when they were talking about which professionals had helped them (which therefore meant the studies were excluded from my review).[65 273 274] In the fourth study, young people spoke about GPs but data was collected in 2001 (before our 2004 cut-off for inclusion).[275]

There are several weaknesses to the data included in my review. These are summarised in Appendix 6.13.

Summary of key findings from the literature review

- 14 studies reported that parents, young people, adolescents and (though rarely included) children had highly variable experiences and views of GPs.

- Negative and positive accounts centred round a few key factors: feeling that the GP was welcoming and was someone to turn to, feeling as if the GP had time to hear about problems, was interested in the patient and took them seriously, feeling as if the GP was empathetic, being treated respectfully (not feeling judged or patronised). A further key theme was the role of GPs for social problems: some participant felt that GPs only dealt with 'medical' problems while others perceived a broader role for GPs but felt that GPs were too keen to find 'medical' solutions.

- Variation in experience is likely to be driven by differences between individual GPs and their professional practice as well as the vagaries of inter-personal relationships between two actors.

- High variability in views and experiences of GPs might be a familiar pattern across all professional "helping" services. GPs might not be any worse than other professionals at engaging and forming relationships with children, young people and parents.

- Given the nature of the data, we were not able to quantify how common specific experiences were across the population in the UK.

Implications of findings of the literature review

Given the probable importance of the GP-patient relationship for facilitating direct responses to maltreatment-related concerns, high variability in secondary school age

children, young person and parent experiences of their GP challenges the feasibility and safety of implementing direct responses in general practice. As described in section 6.4.1, p. 240, GPs seem to recognise the importance of the doctor-patient relationship for engagement and affecting change in parents of children who prompt maltreatment-related concerns and, at least some GPs invest time and effort in these relationships, both within the scope of the ten minute consultation but also beyond. However, we cannot assume that this is consistent across the country nor that the patients experience the relationship in the same way as the GP intended.

6.5.5 Vulnerable families meetings: what form should they take?

Although meetings to discuss maltreatment-related concerns in general practice are recommended by the RCGP, there is little guidance about what how they might be implemented by practices or what forms they might best take. The variability of the four meetings I observed raises many questions, for example about: frequency, attendees and selection of families. From my results in the context of current literature, I would suggest five key facilitators of a fit-for purpose vulnerable family meeting (based on my data, a fit-for-purpose meeting is one that promotes monitoring and follow-up of children and their families, good risk assessment, shared risk, joint-working, learning, peer supervision and joint decision making about referral to children's social care and/or continued management within primary care services).

6.5.5.1 Clear goals

Effective team meetings in other patient groups in primary care are characterised by clear goals[276] and it is likely that this would also improve the functioning of vulnerable family meetings.

6.5.5.2 Flow of meaningful information into the meeting

In the meetings I observed, GPs relied on health visitors to act as a conduit for information from children's social care and/or the police and to bring to the meeting detailed information that they had collected during home-visits. There are several challenges to using health visitors to underpin the monitoring, risk assessment and risk

sharing functions of the vulnerable family meeting in this way. Health visitors only work with families with preschool-aged children (though they may extend their work to older siblings)[277], their caseloads may not overlap with the geographical area covered by GP practices (i.e. they only work with some of the families registered at the practice); and they may not have time, energy or incentives to attend GPs' vulnerable family meetings. Health visitors may not themselves receive important information from other agencies: in their overview of a series of studies about safeguarding children in the UK, Ward and Davies reported that heath visitors were just as frustrated as GPs at the lack of feedback from children's social care.[60] As discussed in section 6.4.2.1, p.252, the interview data from our study also revealed that health visitors they may not pass on all relevant information to the GP even if they are aware of it and even if they attend the vulnerable family meeting. As described above, assuming that health visitors know and share relevant information from other agencies might leave GPs erroneously thinking they have the bigger picture and impede good risk assessment and monitoring. It might also place an unfeasibly large burden on the overstretched health visiting service.

One alternative would be to create a system for regulated information exchange such as automatic notifications of referrals to police or children's social care or an electronic database that could be shared across agencies. However, this type of 'techno-rational' solution[278] has been criticized for prioritizing administrative work and formulaic agency responses over thoughtful practice and therapeutic work with children and families[44 279-281]. As Hall argues in his analysis of inter-professional communication in public enquiries into child death, we should not assume that it is easy or simple to transfer 'information' from one professional to another.[280] Professionals from different agencies will draw on the rules, beliefs and habits of their profession to make (different) interpretations of the same piece of 'information'.[282] Even when information is shared, the meaning of that information can easily get lost as it changes hands, especially in the context of child protection work which engenders professional anxiety, uncertainty and vulnerability to blame. 'Lost' information might be exaggerated with automatic systems, which also threaten to deluge general practice in

the sheer volume of information they might receive about their patients, for example domestic violence incidents via the police.

Another alternative would be to resource another professional whose job description included collecting ensuring information flow into the meeting from social care, education and health visitors and feed back to these agencies. This professional could be located either within primary care or within children's social care. A similar role already exists in some hospitals in the UK in the form of liaison health visitors and paediatric liaison nurses. Collecting information prior the meeting might improve its function: a qualitative study of team working for patients in Belgium primary care reported that well-planned meetings worked best.[283] Any member of liaison staff would have to be sufficiently skilled to elicit and transfer the *meaning* of information, which might require interagency training[60] and to ask questions around the information exchange rather than passively accepting what they hear.[280] There are obvious resource implications of using a trained and skilled professional to fulfill this role.

6.5.5.2.1 Systematic ways of identifying cases for discussion

In the observed meetings, there was a clear need for systematic ways of selecting children and families for discussion. This might be achieved, for example, by identifying children from codes in their electronic primary care records and cross referencing concerns with children and parents known to be vulnerable by other professionals (as in practice B, Table 6-5) or by selecting families where parental risk factors are known to the GP practice, such as domestic violence, drug and alcohol abuse and suicide attempts. This latter approach is already used throughout all Dutch ED departments[284-286] and in some English EDs[287] to identify at risk children. Any protocolised selection of children for discussion might also require a filter of professional concern about the child, to make the meeting directly useful to practice[283] and to make numbers manageable.

Having a systematic way of identifying children and families for discussion at the meeting might minimize disruption from the absence of key staff and avoid reliance on

professionals' memory, confidence and motivation to bring cases to the meeting. The simple intervention to improve coding of maltreatment-related concerns which I developed with the RCGP (reported in Chapter 3) increased coding by about 30% in the 10 practices in England (personal communication from RCGP). Giving codes a specific and visible purpose (using them to "case-find" for the vulnerable family meetings) might also promote recording of concerns.

6.5.5.2.2 Limiting attendance to core members of the primary care team

There is a high level of anxiety and professional vulnerability in child safeguarding work, which can muddle and overwhelm professionals. [44 279 288 289] Qualitative studies have described how defences to anxiety and vulnerability creep into team work and joint-working practices.[279 289] The pre-occupation with confidentiality and the reluctance to admit that "the ball had been dropped" that I observed in two meetings might be exactly this type of defence and have been descried as such elsewhere.[279 289] A paralyzing pre-occupation with confidentiality is commonly described in joint child safeguarding work between social works and health professionals. [61 248]

Keeping the meetings small (limited to the core primary care team) might help create a 'safe space' which allows for the uncertainty and 'not knowing' in concerns about child abuse and neglect and has been described as essential for thoughtful practice and peer support in child safeguarding work within children's social care[279]. As opportunities for informal professional reflection, peer review, team building, and moral support are squeezed by a target-based primary care system[290], a formal 'safe space' might be increasingly important.

The evidence-base does not clearly tell us whether it is better to have small homogenous groups of primary care professionals in vulnerable family meetings or to have larger interdisciplinary meetings. A literature review of team work for complex patients in primary care concluded that occupational diversity in a team promoted positive impact on patient care.[276] However, other qualitative studies of interdisciplinary teams for late-stage dementia in primary care[291] and child safeguarding work[248] report that true collaborative discussion and joint-working rarely

took place, and could even be absent in the context of co-location of professionals.[248] Co-locating social workers in paediatric primary care settings was one component of a multi-component intervention that improved health outcomes of vulnerable and maltreated children.[138 139] On the other hand, our data suggest that inviting social workers to vulnerable families meetings will only work if there is complete professional trust and ease between the social workers and primary healthcare professionals, taking an unfeasibly long time to build and rebuild each time a social worker changed post.

In an ideal world, professionals from other agencies could come to a vulnerable family meeting and engage in uninhibited and profitable discussion and joint decision making. But it seems that this is not so easy to achieve in practice. Limiting attendance at the meetings to the core primary healthcare team might be the type of 'street level' solution that Hood describes as being a practical solution to the inherent messiness and ambiguity ('the swampy lowlands') of everyday practice.[281]

If vulnerable families meetings were limited to the core primary healthcare team, there would be need of structures to challenge assumed and dominant ways of working and to promote inter-agency working outside the meeting. Such structure would guard against meetings which reinforced 'routine dysfunction practice' [51] promote inter-agency working to avoid 'silo working'. [81] Inter-agency training might be a one way of doing this, although the same review that reported inter-agency training to be a positive and valued way of promoting inter-agency trust also reported that GPs rarely attended.[60] Given the monitoring role of LCSBs and statutory requirement for GP led clinical commissioning groups to sit on these boards, LSCBs might be able to help promote interagency working around children discussed in vulnerable family meetings. However, LSCBs face significant challenges in term of participation, leadership and resources.[60]

6.5.5.2.3 Locating the meeting as part of routine clinical practice

Lastly, locating the vulnerable family meeting as a part of the routine work of general practice might facilitate motivation of the team (by labelling safeguarding as core

clinical work) and frequency of meetings. As described in the results section of this chapter, locating safeguarding as 'medical' work was one of the drivers of GP motivation to get involved with maltreatment-related concerns (see section 6.2.5.1, p. 215). There are already similar clinical meetings for other groups of patients and vulnerably family meetings may be modelled on meetings recommended in the The Gold Standards Framework for end-of-life care. Locating the vulnerable family meetings as core clinical practice might also be done by including discussion of vulnerable children in regular meetings about all problems in children, which could also be nested within a meeting about problems about adult patients.

These five suggested facilitators need to be tested in practice.

6.5.6 Is it really child safeguarding?

As so much of what I have identified from the data seems to be part of or similar to routine GP practice, can we really call these responses "child safeguarding"?

My answer would be: yes.

First, the GPs themselves described these responses in the context of concerns about child abuse and neglect. Secondly, the motivation behind the responses was to improve the circumstances of children and reduce the harms of poor parenting. For example, one doctor was coaching a mother in order that she might realize the impact of her drinking on her children and drink less, with the hoped for result that the care of the children improved. Thirdly, the way in which the responses were executed might be specific to concerns about abuse and neglect. For example, although opportune healthcare might be a feature of any good GP consultation, the focus on *immediate* delivery of care might be specific to families who prompt maltreatment-related concerns. Lastly, the reality of child maltreatment is that the GP might not always be able to simultaneously maintain the interests of parents and their child, both of whom might be their patients. The potential for divided loyalties and having to prioritise the child's needs over those of the parent mean that responses to maltreatment-related concerns may occur in quite a different context from other GP work, even if some of the techniques are the same.

In my leaflet requesting feedback from participants on my provisional results, I asked whether participants saw the actions as part of their routine work, safeguarding, child protection or something else. Those who fed back saw the work as both normal practice *and* safeguarding. One GP stated that she would commonly use these strategies for patients with cancer and multi-morbidities. Another GP said that it was normal practice but she paid more attention to these kinds of responses for children with maltreatment-related concerns. Another GP saw that the way that the actions were framed depended on the context:

> “it's "safeguarding" if I'm filling in my eportfolio (as this is the required competence); it's "protecting children" if I'm justifying the time spent; it's normal case management if I'm talking to colleagues or patients.”

Whether or not responding to maltreatment-related concerns is considered “bread and butter” work may be amenable to change. A study which piloted routine questioning about domestic violence by GPs in England found that GPs moved from a position where they viewed domestic violence as a foreign area to one where they considered it part of their normal workload during the study period. By the end of the pilot study, GPs spontaneously located domestic violence in the same sphere as more obviously “medical” work: for example, they compared questioning about domestic violence to questioning about other sensitive areas of general practice, such as sexual health.[292]

6.6 Key points from Chapter 6

- The GPs described actively managing children, young people and families with maltreatment-related concerns.
- GPs seemed to be most actively responding to chaotic families with high health need who were engaged with general practice and had prompted concerns about neglect and to a lesser extent emotional abuse. These were the families for whom it was easiest for the GPs to justify on-going management and with whom they had most contact for other (health) reasons.
- Referral to children's social care was just one component of GP responses in the interviews and observations. I identified seven actions:
    - Recording
    - Monitoring.
    - Advocating.
    - Coaching.
    - Providing opportune healthcare.
    - Referring to other agencies.
    - Working with other agencies.
- These seven responses were consistent with the findings of the only other study in this area in an English setting (which described these type of responses as 'case-holding') as well as wider literature on GP responses to social welfare issues in adults
- As the seven actions draw on core skills of general practice, I hypothesized that there may be considerable existing expertise for enacting these responses in general practice in England. We do not know, however, whether the wider GP population (beyond my small sample) has the time or inclination to do so.

- GPs described the importance of a therapeutic relationship with parents and wider family members and good links with health visitors in order for these seven responses to have a credible chance of working to improve child and family outcomes. Doctors were aware of the dangers of cultivating a reciprocal and trusting relationship with maltreating parents and the only health visitor-doctor relationships that I witnessed and heard about appeared imbalanced and mismatched.

- Vulnerable family meetings seem a promising organisational facilitator of GP responses to maltreatment-related concerns but there remain many unanswered questions about how these meetings might best be implemented.

- We cannot assume that children and families always experience the GP-patient relationship as therapeutic: my review of the literature suggested that there was high variability in child and parent experiences of their GP.

- We know almost nothing about the balance of benefit and harm inherent in these seven responses to maltreatment-related concerns. However, evaluations of interventions which share characteristics with coaching and advocacy (as described by the GPs in my sample) have shown positive impact for help-seeking women with domestic violence and for low and high risk children in a paediatric primary care setting in America.

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7 CHAPTER 7: Mixing methods: integration of findings, conclusions and implications

Statement of authorship

All work in this chapter is my own.

7.1 Content and structure of chapter

In this penultimate chapter of my thesis, I integrate the findings from sub-studies and different data types (qualitative and quantitative) and discuss the strengths and weakness of the mixed methods design.

In the next and final chapter (Chapter 8), I summarise the argument of my thesis, present conclusions and outline the implications of my research.

As this chapter integrates findings from Chapters 3, 4 and 6 there will inevitably be some repetition from earlier chapters. I have endeavoured to keep any such repetition to a minimum.

7.2 What do we learn from putting the data together (mixing methods)?

As I described in Chapter 2 (section 2.5.2, p. 87) my primary reason for choosing a mixed method design was to extend the breadth and range of questions that I could hope to answer. I conceptualised that the findings from each method would act as pieces of a jigsaw which could be put together to gain a more complete picture of GP responses to maltreatment-related concerns. A secondary aim of using a mixed method design was to add depth to my findings about recording of maltreatment-related concerns in general practice (this aim is also described more fully in Chapter 2, section 2.5.2, p. 87). This chapter (chapter 7) addresses each of these aims in turn.

7.2.1 Gaining a more complete picture of GP responses

The results of the THIN analyses (Chapter4) estimated that maltreatment-related problems were coded in almost 1% of children registered with general practice in England in 2010. In England in April 2011, there were just over 11 million children aged less than 18 years or under who were registered with general practice.[95] If we assume that the results from THIN (a large representative database covering nearly 6% of the UK population) can be generalised to all English practice settings, nearly

90,000 children registered with GPs will have had a maltreatment-related code in 2010 or 2011. The development phase (Chapter 3) suggested that maltreatment-related concerns are often recorded as free text entries, scanned letters, 'alerts' on the system or not at all. Additionally, the development phase (Chapter 3) and the analyses of THIN (Chapter 4) suggested that maltreatment-related codes were used as one-off flags for on-going concerns: it was not the same children getting a code each year. In this context, we can assume the point prevalence* of maltreatment-related problems known to general practice in any given year is far more than 1% of registered children. My analyses of THIN data (reported in Chapter 4) suggested there was little between-practice variation over and above that which we might expect from measured child characteristics and random error. In other words there was no evidence of a few "keen" or "expert" practices driving the results.

Together, the data from Chapters 3 and 4 challenge the claim that child maltreatment is not relevant to the average GP (see Chapter 1, section 1.5.4, p.61 for a full description of this claim).

Based on the findings from the development phase (Chapter 3) and the analyses of THIN data (Chapter 4), we are prompted to ask the question "how might GPs respond to all these children with coded concerns and/or recognised maltreatment-related problems?" The in-depth qualitative component of the study generated some hypotheses which begin to answer this question (reported in Chapter 6).

The in-depth interviews and observations generated a rich description of seven possible responses to maltreatment-related concerns in general practice: recording, monitoring; advocating; coaching; opportune healthcare; referral to children's social care and working with children's social care. In addition to referrals and joint working with other agencies, these responses used core skills of general practice with the aim of changing parental attitude and behaviour and

* By point prevalence I mean an estimate of the frequency of maltreatment-related concerns at any single point in time.

preventing/addressing unmet healthcare need in all family members in order to improve the health and welfare of children with maltreatment-related concerns. In the in-depth interviews, the responses that the GPs described using varied according to family type. Most energy and the widest range of responses seemed concentrated on families who were "on the edge".

With the exception of recording of maltreatment-related concerns (discussed below in section 7.2.2, p.315), the results from the routine epidemiological data (THIN) and the in-depth qualitative data do not lend themselves to direct comparisons or detailed integration. The two data sources did not include the same patients or GP practices[6] and recording of maltreatment-related concerns was the only obvious overlap of data about GP practice between the two data sources. We cannot tell how often the responses I identified from the qualitative component were used for children with or without maltreatment-related codes in the THIN data. Nor can putting the two data together tell us with any certainty whether the types of children (and parents) that the GPs discussed in the interviews were the same types of children that received a maltreatment-related code in THIN.

Although there are difficulties in integrating the two data in any detailed way (again with the exception of recoding of concerns), we can interpret the two sets of results in light of each other. Doing so illuminates different aspects of GP practice in this area and has two important implications.

First, without additional resources it is unlikely that GPs could implement the seven responses for the substantial numbers of children who currently have maltreatment-related concerns known to general practice (minimum estimate of 0.8%, from the THIN data). Any policy recommendations for enacting the on-going

[6] One of the four practices from which I collected interview data used Vision software and is therefore eligible to contribute data to the THIN database. However, due to the imperative for anonymity of practices in THIN data, there is no way to confirm whether this one practice did contribute data within the time-period of my epidemiological study (1995-2010). Even if the practice was included in THIN data, its records would represent a very small proportion of the total THIN data which was taken from 448 practices.

and time-intensive responses that I identified will have significant resource implications and will require proper resourcing.

Secondly, the results from the qualitative data take on a new importance when we consider that the responses I identified *could* be used for at least 0.8% of children registered with general practice annually in England. The increasing incidence of already-known maltreatment-related problems in general practice creates a strong imperative to take seriously the results from the qualitative data and lends credibility to the argument that these responses need to be tested for feasibility, acceptability, effectiveness and safety.

7.2.2 Gaining depth of understanding about recording of concerns

In this section, I describe how integrating data from Chapters 3, 4 and 6 added depth to understanding maltreatment-related concerns.

Putting the in-depth interview data (Chapter 6) together with the THIN data (Chapter 4) does shed some light on the coding of chronicity and complexity of problems. Chronic, multiple and inter-related family problems were a key feature of the GP descriptions of "stable at this point" and "on the edge" families and, to a lesser extent, "was it, wasn't it" families in the in-depth interviews (Chapter 6, Table 6-2, p. 210). However, neither this chronicity nor complexity was reflected in the way that maltreatment-related codes were used in THIN data: 85.7% of children with a maltreatment-related code had only **one** maltreatment-related code in their whole time at risk (Chapter 4, Figure 4-2,p. 153) The disjoint between the results from the two types of data might mean that the families described in the in-depth interviews cannot be considered to represent the majority of maltreated-related concerns in general practice, which are in fact acute and time-limited. Alternatively, and more plausibly, the disjoint may confirm the idea voiced in the GP workshop: codes are often used by GPs as a one-off flag for chronic and complex maltreatment-related concerns. If this is the case, estimating cumulative incidence of maltreatment-related concerns a) over childhood and b) over a period of a few years (e.g. 2005-2010) is more likely to get closer to an accurate estimate of coded

concerns in general practice than using annual incidence. Given the focus on dealing with concerns via the parent (Chapter 6), it is likely that cumulative prevalence of household concern over childhood using linked parent and child records would give the most accurate picture of recorded concerns. From a practice point of view, the use of codes as a one-off flag points to the importance of coding concerns as a "significant" or "active" problem so that GPs opening the child's record can see the code even if it was entered months ago (without scrolling through many pages of notes).

In the in-depth interview data two GPs raised the possibility that the nature of coding was changing with a move away from "vague" codes to specific and fact-based codes (Chapter 6, Table 6-4, p. 231). Any such change is not visible in the analyses of THIN data. Table 4-2 (Chapter 4, p. 156) shows a very similar average yearly increase in the THIN data between 1995 and 2010 in child protection codes (which could be considered fact-based) and "high risk child" codes (which include more "vague" codes such as "vulnerable family" and "child at risk").

There was a suggestion from one GP in the interview data that the discrepancy between known and coded maltreatment-related problems might be greatest for children who give rise to concerns about chronic neglect and emotional abuse (rather than other forms of maltreatment) because these "nebulous" concerns are most difficult to code. It was not possible to use the results from the THIN analyses to confirm or challenge the view that there is differential under-coding according to the characteristics of the maltreatment.

7.2.3 Strengths and limitations of my mixed methods design

My mixed methods study design has generated a practitioner-relevant measure of maltreatment-related concern in general practice, provided a deeper understanding of the ways that concerns are recorded in general practice and quantified the minimum burden of recognised maltreatment-related concerns whilst also providing a rich description of possible responses. The generalizable epidemiological results lend importance to the qualitative results and the

qualitative results begin to answer questions prompted by the epidemiological analyses (about how else GPs might respond to the high numbers of children with a maltreatment-related concern already known to general practice). The breadth of my findings and key messages would not have been possible using a single method or data source.

As outlined in Chapter 2 (section 2.5.6, p. 94), all mixed methods studies face the challenge of integrating the different data in order to improve understanding in a way that could not be achieved through either method alone. My study was no exception. Indeed, integration of the data in my design was particularly challenging for two reasons. First, my primary data sources (THIN dataset and interviews/observations) did not overlap substantially in terms of research subjects, topics or themes. Secondly, because I chose a concurrent mixed methods design (data analysed simultaneously and separately with integration at the conclusions and implications stage), the sub-studies could not substantially influence each other as I progressed. With hindsight, I might have gained additional insights from a mixed methods design in which the quantitative analyses were completed before designing and conducting interviews and could therefore shape the data collected in the interviews. This way we could have gained GP perspectives on questions such as "why is the incidence of maltreatment-related codes increasing?" and "Do responses to children with child protection codes differ from those with "high risk" codes?" Alternatively, had the qualitative analysis come first, I would have perhaps included parental records in my estimation of maltreatment-related concerns, time permitting.

On the other hand, I am not sure a sequential design would have been feasible within the time constraints of a three year PhD and the findings would likely have lost the strength of the unstructured interviews in which participants talked about things that *they* had chosen to discuss: the interview data was truly participant-driven.

One way to improve the gains from mixed methods studies using routine quantitative data would be to sample the qualitative data collection sites from the sites included in the routine dataset, which in this case was the THIN database. Sampling practices from THIN for in-depth qualitative work would have allowed me to understand more about the variation (or lack thereof) between practices by, for example, interviewing GPs in practices with low, medium and high rates of maltreatment-related codes. Using THIN as a sampling frame would require breaking anonymity of contributing GP practices and it would be unfeasible to obtain patient consent, both of which presents significant ethical and practical challenges. An even more ethically challenging but potentially fruitful study design would be to identify patients within the routine data and then undertake qualitative analyses to further understand this patient and how s/he was managed.

However, based on the potential gains from combining analyses of routine data with in-depth qualitative research, using routine data to sample sites or patients for in-depth qualitative work warrants further consideration. This is especially true in the context of Care.data: a programme led by NHS England which aims to extract all patient data from GP records for use in research, effectively producing a complete national sample akin to the national sample we already have for hospital admissions (Hospital Episodes Statistics (HES) data).[*293] Via linkage with HES, Care.data will offer the possibility of identifying GP practices contributing to Care.data. However, ethical questions about such a study design remain

[*] Care.data data was conceived of prior to the 2012 Health and Social care Act which made it a legal responsibility for all healthcare providers, including GPs, to share information with the Health and Social Care Information Centre (HSCIC; which was set up in 2013 in order to provide a secure environment for the activities of Care.data and, more widely, to gather, analyse and distribute information about health and social care activity (correct at time of writing in April 2014).

Initially it was envisaged that the HSCIC would start extracting GP in Spring 2014 but this has been delayed due to lack of clarity over the proposed use of the data and controversy about the public information campaign. For more information on Care.data see: Medical Protection website. Care.data- what you need to know. Available http://www.medicalprotection.org/uk/england-factsheets/care-data-what-you-need-to-know. Accessed 2014 April 28.

unanswered especially in relation to the thorny problem of individual patient consent.

7.3 Key points from chapter 7

- The epidemiological analyses of THIN indicated that substantial numbers of children already have maltreatment-related concerns known to general practice in England and suggest that the average GP is likely to face decisions about how to respond to these children. The THIN data confirmed the relevance of my qualitative work which focused on wider GP responses. The in-depth qualitative component of the study generated some hypotheses about how GPs might respond to all these children with known concerns.

- The results from the qualitative data take on a new importance when we consider that the responses I identified *could* be used for 1% or more of children registered with general practice annually in England. The increasing incidence of maltreatment-related codes in general practice creates a strong imperative to take seriously the results from the qualitative data and lends credibility to the argument that these responses need to be tested for feasibility, acceptability, effectiveness and safety.

- Together the quantitative and qualitative data tell us that GP responses to maltreatment-related concerns are an important and promising area for a future randomised controlled trial which measures benefit and harms to children, families and services.

- My mixed method design has provided a more complete picture of GP responses to maltreatment-related concerns that would have been achieved through using quantitative or qualitative data alone.

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8 CHAPTER 8: Discussion

Statement of authorship

All work in this chapter is my own.

8.1 Content and structure of chapter

In this final chapter, I summarise the argument of my thesis, describe what this study adds, present my overarching conclusions and outline the implications of my thesis in terms of policy, practice and future research.

8.2 Argument in my thesis: summary

In my introductory chapter (Chapter 1), I explained how the conceptualisation of maltreatment as part of a spectrum of child welfare, an appreciation of the sheer size of the problem and the limitations of children's social care services in responding to children with maltreatment-related concerns has led to a broadening of focus among researchers and policy-makers when considering how we should respond to the problem. It is clear that health professionals require a *range* of responses for concerns about child maltreatment and that these responses must be wider than (but include) referral to and joint working with children's social care. Also in my introductory chapter (Chapter 1), I describe why particular attention has been paid to the potential of the GP for responding to child maltreatment whilst also highlighting that not everyone agrees that GPs can and should play a central role in child safeguarding. My literature and policy reviews (also reported in Chapter 1) demonstrated that wider responses in general practice have not been fully defined: policy recommendations remain broad-brushed and there is a lack of research evidence to guide policy and practice.

The data in Chapters 3 and 4 suggested that, although recognition could undoubtedly be improved, large numbers of children in England have maltreatment-related concerns already known to general practice. I argued that the lack of unexplained between-practice variation in recorded maltreatment-related concerns suggested that responding to these concerns was a relevant issue for the average GP in England.

In Chapter 6, I provided a detailed and contextualised description of seven possible GP responses which go beyond (but include) referral to children's social care and joint working with this agency. I explained how the GPs in my sample saw relationships with

parents and with health visitors as essential for successfully fulfilling the self-ascribed roles of monitoring, coaching, advocacy and providing opportune healthcare for families with maltreatment-related concerns. Based on the interview and observational data as well as wider literature, I highlighted the potential harms of some of the seven responses, especially if enacted in the context of insufficiently robust relationships with parents, young people or health visitors.

Also in Chapter 6, I explained why the types of families described in the interviews were likely to be familiar to GPs and described how the seven responses to maltreatment-related concerns employed core skills of general practice. I hypothesised that there may be an existing skill-base necessary to implement these responses in general practice, although it is more unclear whether the average GP has time or inclination to do so. Finally, I highlighted that my descriptions of GP responses are consistent with the little other empirical research in this area and hypothesised that my findings may well be relevant beyond the practices that I recruited to my study.

In Chapter 2, I described my mixed methods design and the rationale behind it. In Chapter 7 I reflected on this design and outlined what we gained from integrating the data types. I argued that the epidemiological analyses of THIN confirmed the relevance of my qualitative work which focused on wider GP responses. The in-depth qualitative component generated some hypotheses about how GPs might respond to some of the children with known concerns who were identified in the THIN data. Also in Chapter 7, I outlined where the qualitative and quantitative data together provided depth of understanding about recording of maltreatment-related concerns. Recording was an obvious area of overlap between the data.

8.3 What does this PhD study add?

This thesis provides evidence in an area where there is very little existing evidence to support policy and practice. As far as I am aware, this thesis is only the second study to investigate GP responses to child maltreatment in an English setting. It is the first study both to provide generalizable findings about GP responses to child maltreatment by

using large and representative data and also to provide a very detailed description of possible GP responses and their context. The description of the seven responses and the estimate that almost 1% of children have a maltreatment-related code in their record can be used as a basis for developing a package of care aiming to improve outcomes for children, young people and their families. Such a package of care can eventually be rigorously tested for both benefit and harm.

As part of the development phase (Chapter 3, Appendix 3.1), I contributed to the development of a new approach to coding maltreatment-related concerns which is now recommended by the RCGP and has since been adopted by some practices in England.[7]

This thesis presents a measure of maltreatment-related concerns based on a collection of Read codes. Developing and understanding this measure took time and expertise. The measure is practitioner-relevant, having been developed in collaboration with GPs and aiming to identify codes pertaining to "considered" maltreatment, the minimum threshold for professional action as defined by NICE guidance (see Chapter 1, Table 1-2, p. 64 for a description of this threshold).[128] Future studies using routine primary care data from England can employ this measure of maltreatment-related concerns (e.g. studies using THIN, the General Practice Research Database or possibly Care.data).

8.4 Strengths and limitations of PhD study as a whole

The study as a whole was subject to the strengths and limitations of each of the data sources and methods used and these are discussed in detail in the chapters relating to each of the sub-studies (Chapters 3, 4, 5 and 6) as well as in my reflections on the mixed methods design (Chapter 7). In the following section, I will outline the overarching strengths and weaknesses of the whole study.

[7] Personal communication at the AGM of the Primary Care Safeguarding Forum in Oct 2011 and Oct 2012

Collaborative approach

My highly collaborative and interdisciplinary approach was one of my study's key strengths. GP collaborators shaped my conceptualisation of the problem, the nature of the research questions and definition and measures of maltreatment-related concerns. Involving GPs so heavily in my work has maximised relevancy to practice and policy and also created GP ownership of the results: the RCGP has supported the new approach to coding (reported in Chapter 3) and is giving its backing to a forthcoming report which will include my literature reviews (Chapter 1) and in-depth qualitative results (Chapter 6). Joint publications with the RCGP have maximised dissemination and impact of my study. Exposure to GP culture via collaborations in the early stages of my study undoubtedly helped me to overcome the particular challenges associated with recruiting "elite interviewees"[8] to in-depth qualitative work and accessing their "private" accounts.[159] However, close collaborations with GPs also created a problem. As described in Chapter 5 (3.6, p. 131), good qualitative research hinges on the researcher's ability to be simultaneously an insider and an outsider. If the researcher becomes too much of an insider ("goes native"), they jeopardise their position as an active and critical observer and risk becoming just another participant in the field.[159] I have been alerted twice to this problem in my work: once my MPhil-PhD Upgrade examiner who warned me of uncritically accepting rhetoric from the RCGP; and once from one of my health visitor participants who perceived the preliminary interview results to be excusing and justifying what she saw as GP's dangerously poor joint working. I have sought to minimise this problem by continued awareness, seeking other professional view-points (health visitors, practice nurses and academics from outside general practice) and reconsidering my approach and perspective in light of relevant comments.

Collaborations with UCL academics outside of my supervisory team gave me access to the THIN database and to guidance from statisticians who were highly experienced in

[8] Interviewees who are relatively more powerful than the interviewer in this case in terms of professional training, social status and (in most cases) age.

using THIN data. My supervisors and collaborators constituted a multi-disciplinary group with epidemiological, statistical and qualitative research skills and expertise in both health and social work research. My mixed methods design and subject of enquiry required that I use a very broad range of data sources and methods and the study design is based on a good understanding of children's social care and as well as general practice. Multi-disciplinary input helped maximise depth and credibility in each of the sub-studies, which was challenging due to the breadth of the study design.

Missing pieces from the puzzle

Although I have attempted to illuminate as much of the big picture as possible, my PhD study is far from a complete picture of GP responses to concerns about child maltreatment by GPs in England. An obviously important but missing piece of the jigsaw puzzle is the perspective and experiences of children, young people and parents who prompt maltreatment-related concerns in general practice. I have tried to partially address this gap by conducting a literature review on the views and experience of general practice from the perspective of parents, young people, adolescents and children (reported in Chapter 6, section 6.5.4.3, p. 296). However, further work should also include the views and experiences of GPs ***and*** the families with whom they are working.

Other missing jigsaw pieces include perspectives from other professionals (notably social workers) detailed information about the possible contribution of the wider primary care team, including practice nurses and administrative staff and the (likely) impact of recent and on-going organizational changes to general practice and commissioning of health care services in England. There may be other important aspects of GP responses to maltreatment-related problems that my PhD study does not address and which neither myself nor other researchers have considered (often we are not aware of what we do not know). These factors may be identified through further in-depth qualitative research with GPs, other professionals and parents.

One final limitation of this thesis is that evaluating the effectiveness and safety of the seven responses, including recording of concerns, was beyond the scope of my study in

terms of time and resources. In order to assess the impact of GP responses on child, young person and parent outcomes for families who prompt maltreatment-related concerns, we ultimately need a randomised controlled trial with an embedded qualitative study to understand the processes and mechanisms of impact (or lack thereof).

8.5 Conclusions

My work presents a more promising picture of child safeguarding in general practice than has previously been offered. On a national level, GPs were recording maltreatment-related concerns and increasingly so. This upward trajectory of recording is likely to continue. Clearly, the GPs in my small sample believed they had a "case-holding" as well as a "sentinel" and "team player" role for children and families who prompted maltreatment-related concerns. The range of possible responses to maltreatment-related concerns identified in this thesis constitutes a promising avenue for further exploration. As the responses were generated from current practice, appear to draw on core GPs skills and are consistent with existing research, they have a good chance of being feasible in wider general practice (beyond my small qualitative sample). In addition, some component of the responses I identified have been thought sufficiently acceptable and promising to have been previously included in interventions to improve healthcare responses to child maltreatment in America and/or women living with domestic violence in England and Australia (as described in Chapter 6, section 6.5.3.2, p. 281).

However, the problem remains a sticky one and there appear to be two major obstacles to taking forward the results of this thesis to improve care for children and families with maltreatment-related concerns in general practice. First, the "case-holder" role, as described by the GPs in my sample, was not acknowledged in policy or practice guidance (with the exception of the monitoring role which was acknowledged in policy but only as a precursor to referral to children's social care.) By not including the "case-holder" role in its vision of the GPs' role in responding to maltreatment-related concerns, government policy does not play to the strengths of general practice

or fully support their potential for effectively responding to child maltreatment. It also means that, if the "case-holder" role is being enacted by some GPs in England beyond my small sample, such activity will continue to occur outside of guidance or monitoring and will remain not costed.

Secondly, there is a lack of evidence about the effectiveness or safety of any GP responses, including those recommended in national policy and practice guidance: ultimately, we do not know whether any responses are effective or safe when used in general practice in England or whether they are acceptable to GPs or families. This is a problem for all interventions in this area, including those delivered by children's social care.[294] My thesis has outlined some potential benefits but also potential harms of GP "case-holding" and other more accepted responses such as recording and referral to children's social care. Throughout my thesis I have recommended that policy-makers, funders of research and researchers prioritise efforts to rigorously evaluate responses to maltreatment-related concerns by GPs in terms of benefit and harm to children and families as well as costs to services. We urgently need randomised controlled trials in this area and a suitable intervention for evaluation is likely to include recording and subsequent and multi-component action, including the seven responses I have identified. It is unlikely that further research on the "case-holder" role will be funded unless policy-makers revise their vision of the GPs' role.

Responding to maltreatment-related concerns will have financial and opportunity costs for general practice. For example, current levels of recording are sub-optimal and there is substantial scope for rates of recording to follow their upwards trajectory. If recording concerns demands additional action, particularly some of the time-intensive responses I identified, further increases in recording will likely have significant resource implications.

My qualitative data supported wider arguments that GPs can be reluctant to engage with the formal child protection system and view multi-agency working as problematic. However, some GPs might be undertaking large amounts of direct work with families which is largely going unrecognised, not only by the current formal child protection

system but also by policy makers. Such direct responses exist outside of any guidance, are unevaluated, unmonitored and not costed into services.

The findings of my thesis challenge policy makers, professionals and other researchers to rethink the GPs' role in responding to maltreatment-related concerns.

8.6 Implications

8.6.1 For policy

- Policy should explicitly acknowledge that universal services will be working with child maltreatment, sometimes in situations where additional support services may not be available.

- Policy-makers should promote responses to maltreatment-related concerns which can be delivered continuously as a package of care in general practice and before, alongside, or after referral to other agencies, including children's social care. Such responses would likely comprise a monitoring and therapeutic support role for the child and parents and include some of the responses identified in my thesis. Such responses might be referred to under the umbrella term 'direct responses'.

- Recording is a necessary but insufficient response to maltreatment-related concerns. Policies about recording concerns could usefully be broadened to address the need for recording to fit with wider responses by GPs.

- It might be difficult to construct proactive care pathways for safeguarding if there is a perception among some GPs and other professionals that GPs should only respond to 'medical' problems. Policy could promote the more helpful view that GPs have a 'medical ticket' which could facilitate relationship building with parents thus providing opportunities for direct responses to maltreatment-related concerns (in some cases).

- Policy-makers should take evidence about current practice as a starting point for developing policy about responses to child maltreatment by GPs. Working with the existing strengths of general practice is likely to generate policy that is feasible, acceptable and has a good chance of being enacted.

8.6.2 For practice

- Other professionals, including other healthcare professionals, should consider the GP as a central player for children and parents who prompt maltreatment-related concerns, including those with problems which don't have an obviously "medical" component.

- Children's social care could ensure that GPs are routinely informed when there are concerns about child maltreatment, regardless of whether the child is made the subject of a child protection plan. Such information is relevant to the healthcare of the child, the parents and siblings registered with the GP.

- Regular team meetings with the primary health care team (and possibly colleagues from secondary healthcare and/or education) appear a promising system for monitoring concerns. They might also facilitate joint-decision making and peer supervision of GP responses such as coaching of parents and advocating for families. If not already holding these meetings, practices should consider dedicating one of their clinical team meetings to vulnerable families. Such meetings can be modelled on similar meetings for palliative care patients. However, these meetings are not without problems: practices must think carefully about the purpose of the meeting, who will attend, how families will be identified for discussion and who is responsible for them when the safeguarding lead is away. While we await further research on the effectiveness and cost of these meetings, it seems common sense to recommend them, especially as the RCGP has already identified them as good child safeguarding practice.

- Practice managers and GP safeguarding leads should consider introducing to their colleagues the simple approach to coding maltreatment-related concerns

developed in Chapter 3. All material necessary for implementation is freely available at http://www.clininf.eu/maltreatment. Although not a magic wand to solve the tricky issues of recording concerns, this is a simple and feasible approach which makes children 'findable' on the system and could generate a list of families for discussion at meetings and/or regular review. GPs might also consider whether recording facts and actions is more acceptable both to themselves and the patients who might ultimately see their records.

- In order to facilitate joint-working with other healthcare professionals and children's social care, GP practices could identify one or two trusted professionals within e.g. secondary care or children's social care who could be contacted when concerns arise. This could potentially be undertaken by the GP safeguarding lead in each practice. However, it would be time-consuming and likely easier with other healthcare professionals than professionals from outside agencies.

- Recognising maltreatment-related concerns through parents and other adults will be most effective if there are practice systems to identify which children live with which adults. Practices should consider improving systems that can identify households and review the information that they collect at patient registration to maximise knowledge about family units. In consultations, GPs should consider whether it is relevant for them to know whether the adult patient in front of them has a dependent child at home.

8.6.3 For research

- There is an urgent need for a cluster randomised controlled trial evaluating the benefit and harms to children and families of a package of care (including direct responses) to maltreatment-related concerns in general practice in England. Such a trial should also measure financial and opportunity cost and include a process evaluation to understand mechanisms for change and impact, or lack thereof.

- Before a good quality trial can take place, the package of care to be evaluated must be further developed. Every element of the package should be properly described and understood and there must be a robust theory about how the package of care will work. This development should be guided by the MRC's framework on developing and evaluating "complex interventions"[*295-297] For illustrative purposes such a package of care might include:

    - training GPs in coding maltreatment-related concerns in child and parent records, as well as relevant decisions and actions.

    - training GPs in monitoring, advocating, coaching and providing opportune health care in the context of families who prompt maltreatment-related concerns.

    - training GPs to handle the triadic nature of the GP-parent-child consultation and relationship in the context of maltreatment-related concerns.

    - regular and/or more frequent team meetings to discuss families who have prompted maltreatment-related concerns and administrative support for these team meetings.

    - training for other local professionals (such as social workers, health visitors or paediatricians) in how to best support the GP in responding to maltreatment-related concerns.

    - implementation of systems for other local professionals to feedback information to GPs.

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[*] There are no clear boundaries between "simple" and "complex" interventions but a workshop of experts identified several dimensions of complexity in "complex interventions". These include: the number of components of the intervention and the interactions between components; the number and difficulty of behaviours required by those delivering or receiving the intervention; the number of groups/organisational levels targeted by the intervention; the number and variability of the outcomes; and the permitted degree of flexibility or tailoring of the intervention across sites/providers. See Craig P, Dieppe P, Macintyre S, Michie S, Nazareth I, Petticrew M. Developing and evaluating complex interventions: the new Medical Research Council guidance. British Medical Journal 2008;337(sep29 1)

- targeting parents instead of (or as well as) children.

- Based on the findings in Chapter 6, a development study could usefully draw on literature relevant to
  - the management of chronic conditions in general practice
  - responses to social "co-morbidities" such as poverty or drug misuse.
  - client / patient engagement in the social care and healthcare literature
  - stages of change
- Based on this thesis, there are four studies which should be prioritised, all of which would also inform the development of a package of care to be tested using a randomised controlled trail in English general practice settings. These are:
  - An in-depth qualitative study of the perspectives and views of parents and young people who have prompted maltreatment-related concern in general practice. This study should also collect the views and experiences of the GPs, practice nurses, health visitors and social workers who are in contact with the families. If possible, data about families and professional responses should be collected from the child and parent's primary care and social care records. Such a study would generate further hypotheses and support/challenge my hypotheses about:
    i. possible responses.
    ii. family types and the relationship with GP responses.
    iii. mechanisms for impact.
    iv. relevant outcomes, including possible adverse effects.

    This study would also increase understanding about how a model of GP practice might work relative to the role played by children's social care.

- An epidemiological analysis of linked data from children's social care and general practice (with linked parent-child general practice data) in a representative sample of children. This would allow us to:
    i. estimate the minimum burden of "active" concerns in general practice by quantifying cumulative incidence (using a measure which took parental records and free-text entries into account).
    ii. describe patterns of contact with general practice and children's social care over childhood in order to draw conclusions about GPs' role relative to that of social workers.
- A survey of a large and representative sample of GPs in England to gain their views about the acceptability and feasibility of each component of a proposed package of care.
- A mixed methods study to generate hypotheses about the best way to implement vulnerable family meetings in GP practices. The study could use routine healthcare data in a comparative study of practices with and without meetings (in various forms) and an in-depth qualitative process evaluation. This would generate robust hypotheses about the active ingredients of these meetings and the impact of small differences implementation. The 'best practice' model of these meetings could eventually go into be tested for effectiveness in a large cluster randomised controlled trial.

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General practitioner responses to concerns about (possible) child maltreatment in England:

a mixed methods study

A thesis presented for the degree of Doctor of Philosophy

University College London

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UCL Institute of Child Health

Volume 2: Appendices

CONTENTS

APPENDIX 1: Supplementary material for Chapter 1

Appendix 1.1: search strategies for literature review

I searched several sources and screened each of the results for relevant studies, concentrating on 'big hitters' (systematic reviews, large primary studies or key policy documents or reports) and literature and policy relevant to England. Results from more than one search source often contributed to the material used to answer each review question. Literature and policy reviews were first conducted between September 2009 and December 2010. Searches were then updated every few months until October 2013 to capture any new material. In some cases, such as the MEDLINE search, I set up a weekly email alert of any new hits from searches which I screened for relevancy.

Table A1.1: Search strategy

Review questions	Search N and Source	Dates of search	Search concepts	Search terms / methods
Are GPs well-placed to respond to child maltreatment? What *should* GPs be doing to respond to maltreatment? What *could* GPs be doing to respond to maltreatment? What *are* GPs currently doing to respond to maltreatment?	#1 MEDLINE, PsycINFO, Social Policy and Practice, Embase. (via Ovid)	Search first run in Dec 2010 with weekly updates and alerts until 1st Oct 2013.	primary care AND (maltreatment OR social welfare) AND child AND since-2000 AND in English.	1. (primary adj care).ab,ti. 2. (family adj physician).ab,ti. 3. GP.ab,ti. 4. (general adj pract*).ab,ti. 5. 1 or 2 or 3 or 4 6. nurse.sh. or nurse.ti. or nurse.ab. 7. 5 or 6 8. (health adj visitor).ab,ti. 9. 7 or 8 10. child abuse.sh. 11. (child adj maltreat*).ab,ti. 12. (child adj abus*).ab,ti. 13. (physical adj abuse).ab,ti. 14. (deliberate adj injury).ab,ti. 15. (non-accidental adj injury).ab,ti. 16. (nonaccidental adj injury).ab,ti. 17. (shaken adj baby).ab,ti. 18. (intentional adj injury).ab,ti. 19. (child adj protection).ab,ti. 20. (neglect or victimisation or victimization or "child in need" or "well-being" or "well being").ab,ti.

Table continued overleaf

Table A1.1 *Continued*: Search strategy

Review questions	Search number and Source	Dates of search	Search concepts	Search terms / methods
				21. (social conditions or social support or social welfare or social work).sh. 22. (safeguard* or welfare or psychosocial or "social work*" or "social care" or "social services").ab,ti. 23. 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 24. 9 and 23 25. limit 24 to (english language and yr="2000 - Current") 26. (child* or adolsecent* or infant*).ab,ti. 27. child.sh. 28. adolescent.sh. 29. infant.sh. 30. 26 or 27 or 28 or 29 31. 25 and 30
	#2 Google	Conducted first in Oct 2009 &last in Oct 2013.	Safeguarding AND GPs (policy).	(safeguarding OR "child protection") AND GP.

Table continued overleaf

Table A1.1 *Continued*: Search strategy

Review questions	Search N and Source	Dates of search	Search concepts	Search terms / methods
	#3 Google scholar	Searched first conducted in Oct 2009 and last conducted in Oct 2013.	Safeguarding AND GPs (research).	(safeguarding OR "child protection") AND GP.
	#4 NSPCC website http://www.nspcc.org.uk.	First conducted in Jan 2010 and updated weekly.	Safeguarding policy relevant to GPs and social work .	Browsed the “research, statistics and information” section, searched for “GPs” in the online library and set up a weekly email alert for “new in the library” publications and reports.
	#5 Snowballing	Conducted throughout period Oct 2009 to Oct 2013.	NA	Using recommendations from supervisors or colleagues, bibliographies of relevant publications, “related publications” link on Pubmed and searching for works by key authors or related to key policy documents.

Continued overleaf

Table A1.1 *Continued*: Search strategy

Review questions	Search number and Source	Dates of search	Search concepts	Search terms / methods
What are the key characteristics of general practice in England?	#6 The Health and Social Care Information Centre website http://www.hscic.gov.uk/.	Searched once in Oct 2012.	Seeking statistics about primary care services.	Browsed "primary care" section.
	#7 UCL library catalogue.	Searched once in Oct 2012	Seeking text books or overviews of primary care.	Searched for "primary care" OR "general practice" in book titles.
What is child maltreatment? How big is the problem?	#8 Google Scholar.	Searched first in Jan 2010 and last in Oct 2013.	Seeking policy, theory and empirical studies on definitions of maltreatment and studies estimating community incidence.	"(burden or incidence or prevalence) AND (child maltreatment)." OR "definition AND (child maltreatment)."
	Also #4 and #5 above.			

Table continued overleaf

Table A1.1 *Continued*: Search strategy

Review questions	Search number and Source	Dates of search	Search concepts	Search terms / methods
What is the role of children's social care and the child welfare system for maltreated children, especially in relation to other professionals?	#9 Google Scholar and Google. Also #4 and #5 above.	Searched first in Dec 2010 and last in Oct 2013.	Seeking policies and critiques of policies and empirical studies, both qualitative and epidemiological.	"child protection social care." "child protection social policy."

APPENDIX 2: Supplementary material for Chapter 2

There is no supplementary information for Chapter 2

APPENDIX 3: Supplementary material for Chapter 3

Appendix 3.1: Developing an improved approach to coding maltreatment-related concerns: method and results

Methods: consensus development

The 11 GP leads were invited to a consensus development workshop in May 2011. I based the consensus development methods on the nominal group technique (also known as "expert panel" method). Like other methods for consensus development, nominal group techniques aim to maximise the benefits from discussion of a problem by a group of experts whilst minimising disadvantages of group decision-making, particularly domination by a few individuals or interests.[1] Table A3.1 outlines the similarities and differences between the stages used in nominal group technique and our workshop. Due to the importance of using a proficient and credible facilitator in nominal group technique, my primary supervisor (RG) facilitated the consensus development.[1 2]

In practice, the ranking exercise (stage 5 in Table A3.1) was difficult to analyse and did not contribute to the consensus recommendations. The prior discussion had already identified a few key concepts, some of which were not on the ranking sheet and, in addition, several GPs misunderstood the ranking exercise.

Table A3.1: Comparison of my methods with nominal group techniques.

Stages of consensus development		
	Nominal group technique[2 3]	Workshop with GPs
1	Introduction and explanation.	Introduction and presentation of results from report.
2	Silent writing of ideas by individuals.	Prior to the meeting GPs were sent a report of the results from previous phases of the study and asked to consider important factors in improving recording of child maltreatment concerns.
3	Contributing of ideas by each individual in turn, without discussion.	GPs contributed their ideas on recording in turn, without discussion.
4	Ideas discussed and clarified by the group.	Ideas discussed and clarified by group and further ideas raised.
5	Ranking and voting by individuals.	Ranking by individuals of key concepts that might be recorded in the child's record by individuals. Key concepts generated from the analysis of current practice in the group (database analysis).
6	Ranking tabulated and presented.	Discussion and recommendations summarised and sent to GPs for comment.
7	Ideas re-ranked by participants individually.	Comments incorporated into notes and recommendations which were sent to GPs for agreement.

Results: a new approach to coding maltreatment-related concerns

In light of the results from the telephone interviews, workshop in May 2010 and the database analyses (described in Chapter 3), the group of GPs developed and agreed a series of principles to guide a recommended approach to coding during the workshop in May 2011. The GPs agreed that simplicity and ease of implementation were key and the following recommendations were made (see Figure A3.1 for recommended coding pathway):

1) GPs should always and as a minimum use the code "child is cause for concern" whenever child maltreatment is "considered".

- "Child is cause for concern": 13If – Read 2 (5Byte) or XaMzr – CTv3.

2) Further detail of the case should be coded or not as felt appropriate by the GP. Important concepts to hold in mind include:

a. Why is the child cause for concern?

Use free text to record observations or information that prompted concern.

b. Is the family cause for concern?

Family risk factors – record in the child's records if the GP considers they are clinically relevant to the child's risk of potential harm.

c. Are child protection services or children's social care involved?

Record any contact with children's social services, including whether the child is fostered or living in other forms of statutory care or living informally outside the family home.

d. What other professionals are involved?

Use codes for other professionals, e.g. health visitor, community paediatrician and police.

The full list of recommended codes for each of these four concepts is available below in Table A3.2 and at http://www.clininf.eu/maltreatment

Figure A3.1 shows the recommended coding pathway for the four concepts.

3) GPs should be encouraged to code further details of the case on the opening or default screen and to use free text if necessary.

4) A code should be entered when the child is no longer a cause for concern and when a child protection plan is discontinued.

5) Recommended codes should be usable in all UK general practice software systems.

6) A short, one-page data entry form (also known as a "template") could help to implement the recommendations and would further standardise coding of elements of the history.

7) Entries would automatically be tagged with the date entered, type of event (e.g.: consultation, telephone call, social services report), and who entered the code).

A3.2: Additional recommended codes, grouped into four concepts

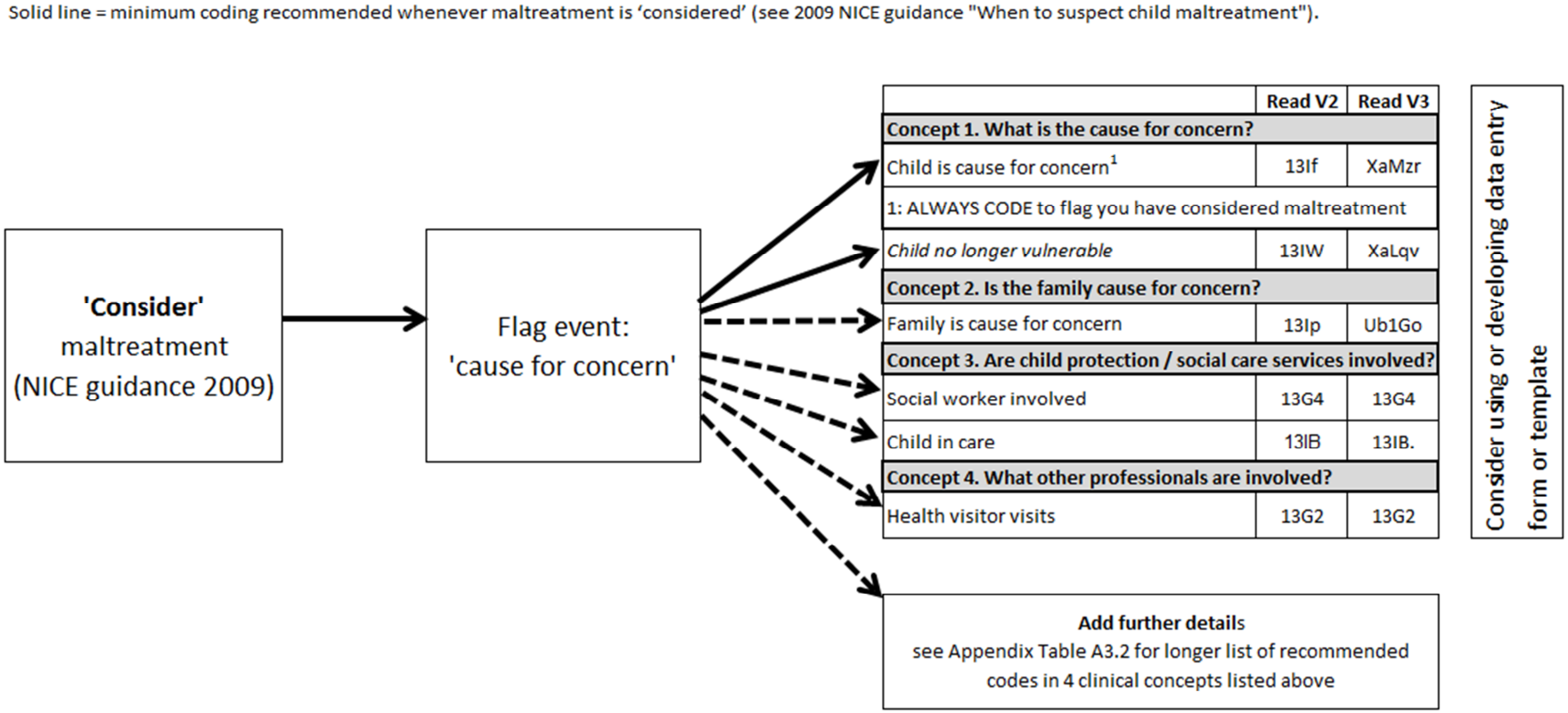
1. What is the cause for concern?		Read V2	Read V3
Non-specific.	Child is cause for concern (1).	13If	XaMzr
	Child no longer vulnerable (2).	*13IW*	*XaLqv*
	Suspected child abuse.	1J3.	1J3
	History of abuse.	14X.	XaWFq
Specific.	At risk of neglect.	13ZV	XaKbs
	At risk of emotional abuse.	13ZR	XaKbP
	History of emotional abuse.	14X2	XaEft
	At risk of physical abuse.	13VF	XaKbR
	History of physical abuse.	14X0	XaEFr
	At risk of sexual abuse.	13ZW	XaKbT
	History of sexual abuse.	14X1	XaEFs
	A/n care: social risk.	625	625
2. Is the family a cause for concern?		**Read V2**	**Read V3**
Family cause for concern.	Family is cause for concern.	13Ip	Ub1Go
	Family member no longer subject of a child protection plan.	*13Iz*	*XaPkG*
	Paternal drug misuse.	12X2	XaPDT
	Maternal drug misuse.	63C6	63C6
	Both parents misuse drugs.	12X1	XaPDU
	Maternal alcohol abuse.	63C7	63C7
	Alcoholic in family.	1282	XM1jq
	At risk violence in the home.	13VF	13VF
	History of domestic violence.	14X3	XaJhe
3. Are child protection / children's social care services involved?		**Read V2**	**Read V3**
Child protection.	Child protection procedure.	64c	Ub0ex
	No longer on child protection plan.	*13Iw*	*XaOtl*
	Child protection investigation.	Z352	UbOez
	Social services case conference.	3875	3875
	Child subject of a child protection plan.	13Iv	XaOnX
	Family member subject to a child protection plan.	13Iy	XaPkF
Contact with children's social care.	Social worker involved.	13G4	13G4
	Refer to social worker.	8HHB	8HHB
	Report received from social service.	9NDA	XE2NS
	Child in need.	13IS	XaEFq
	Child no longer in need.	*13IT*	*Xa1087*
Looked After children.	Child in care.	13IB	13IB
	Foster care.	8GE7	8GE7
	Fostering medical examination.	6982	6982
	Child lives with another relative.	13Ic	XaMFL
	Child lives with an unrelated adult.	13Iu	Xa0in
4. What other professionals are involved?		**Read V2**	**Read V3**
Healthcare/ other professionals involved.	Health visitor visits.	13G2	13G2
	Under care of paediatrician.	9NNg	XaAPa
	Seen by community paediatrician (V2=seen in paed clinic).	9N1V.	XaASU
	Seen by chlid and adolescent services.	9No0	XaAXM
	Under care of school nurse.	9NNP	XaAQt
	Police record.	13JN	XE0pj

(1): Always code to flag concern in all children win whom maltreatment is 'considered' (as defined in NICE guidance). This is the minimum coding that we recommend for any child with concerns.

(2): Use to indicate the end of a period of professional concern.

All 11 GPs agreed to implement the new approach to recording maltreatment-related concerns in their practice and to take part in another audit a year after the six month implementation phase. I did not lead on the second data collection or analysis and the methods and results are not included in my thesis. The results from the second data collection are due to be published in late 2014 (correct at time of writing in April 2014).

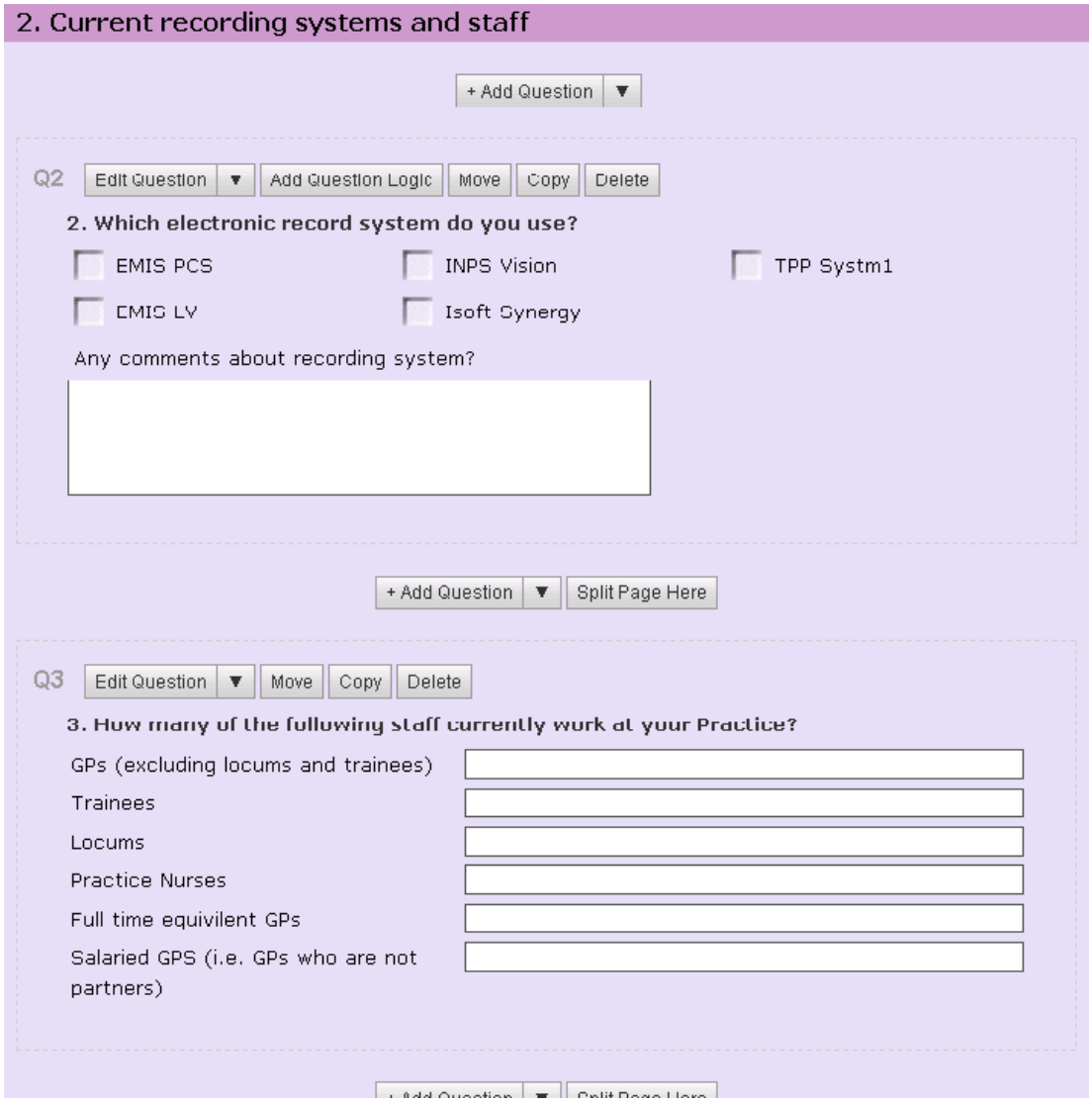
Figure A3.1: Recommended coding pathway



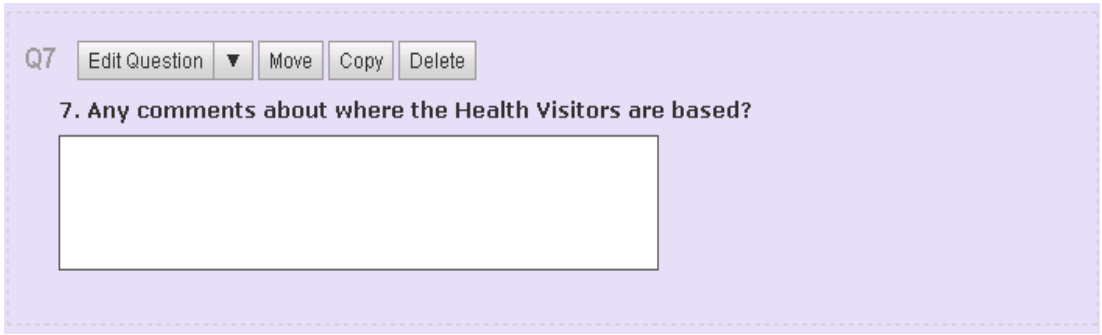
Appendix 3.2: Online questionnaire sent to 11 GP leads

The questionnaire was conducted using an online too (Survey Monkey interface) in April-May 2010. Screen prints of the survey are appended below.

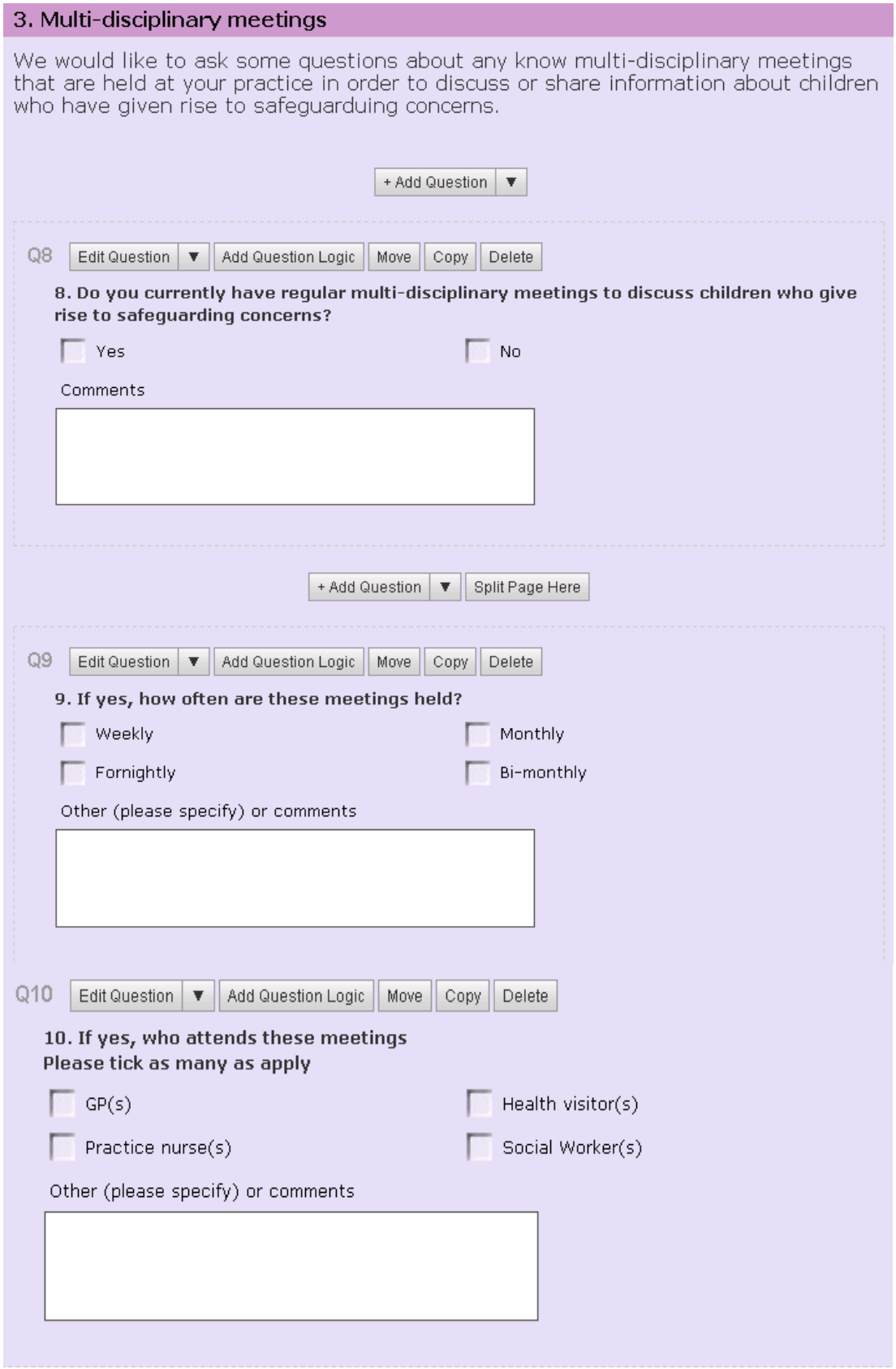
Appendix 3.2: *Continued*: online questionnaire sent to GP leads at 11 participating practices



Appendix 3.2: *Continued*: online questionnaire sent to GP leads at 11 participating practices



Appendix 3.2: *Continued*: online questionnaire sent to GP leads at 11 participating practices



3. Multi-disciplinary meetings

We would like to ask some questions about any know multi-disciplinary meetings that are held at your practice in order to discuss or share information about children who have given rise to safeguarduing concerns.

+ Add Question ▼

Q8 Edit Question ▼ | Add Question Logic | Move | Copy | Delete

8. Do you currently have regular multi-disciplinary meetings to discuss children who give rise to safeguarding concerns?

☐ Yes ☐ No

Comments

+ Add Question ▼ | Split Page Here

Q9 Edit Question ▼ | Add Question Logic | Move | Copy | Delete

9. If yes, how often are these meetings held?

☐ Weekly ☐ Monthly

☐ Fornightly ☐ Bi-monthly

Other (please specify) or comments

Q10 Edit Question ▼ | Add Question Logic | Move | Copy | Delete

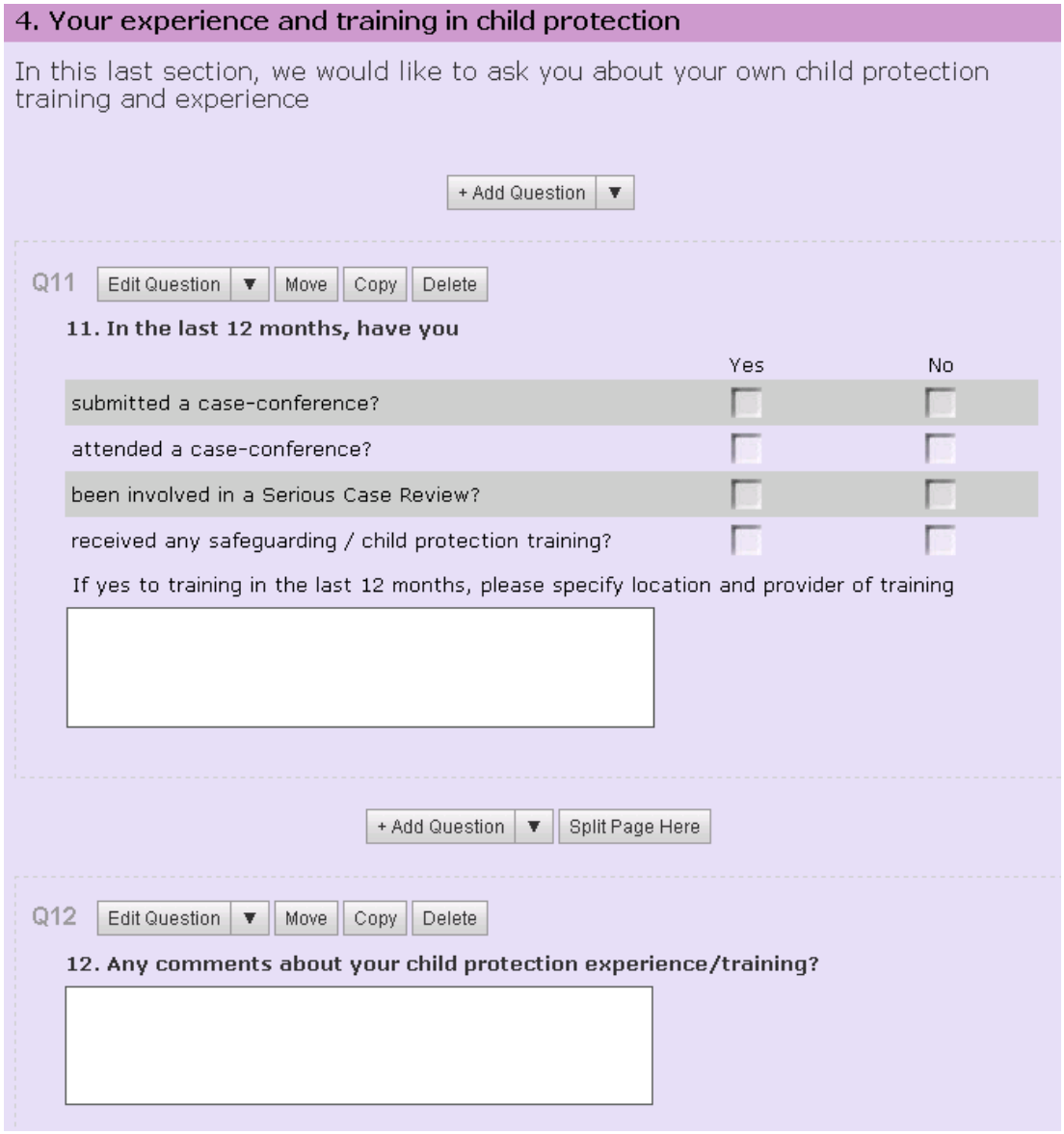
10. If yes, who attends these meetings
Please tick as many as apply

☐ GP(s) ☐ Health visitor(s)

☐ Practice nurse(s) ☐ Social Worker(s)

Other (please specify) or comments

Appendix 3.2: *Continued*: online questionnaire sent to GP leads at 11 participating practices



4. Your experience and training in child protection

In this last section, we would like to ask you about your own child protection training and experience

+ Add Question ▼

Q11 Edit Question ▼ Move Copy Delete

11. In the last 12 months, have you

	Yes	No
submitted a case-conference?	☐	☐
attended a case-conference?	☐	☐
been involved in a Serious Case Review?	☐	☐
received any safeguarding / child protection training?	☐	☐

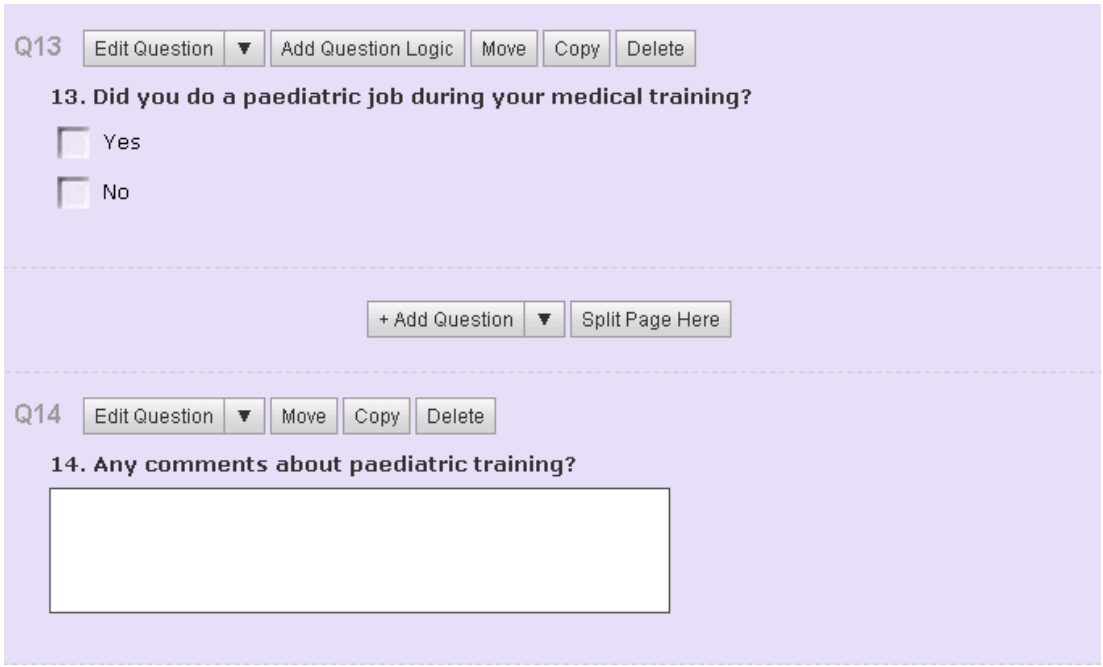
If yes to training in the last 12 months, please specify location and provider of training

+ Add Question ▼ Split Page Here

Q12 Edit Question ▼ Move Copy Delete

12. Any comments about your child protection experience/training?

Appendix 3.2: *Continued*: online questionnaire sent to GP leads at 11 participating practices



Appendix 3.3: Keywords used to search the description field in the Read code dictionary

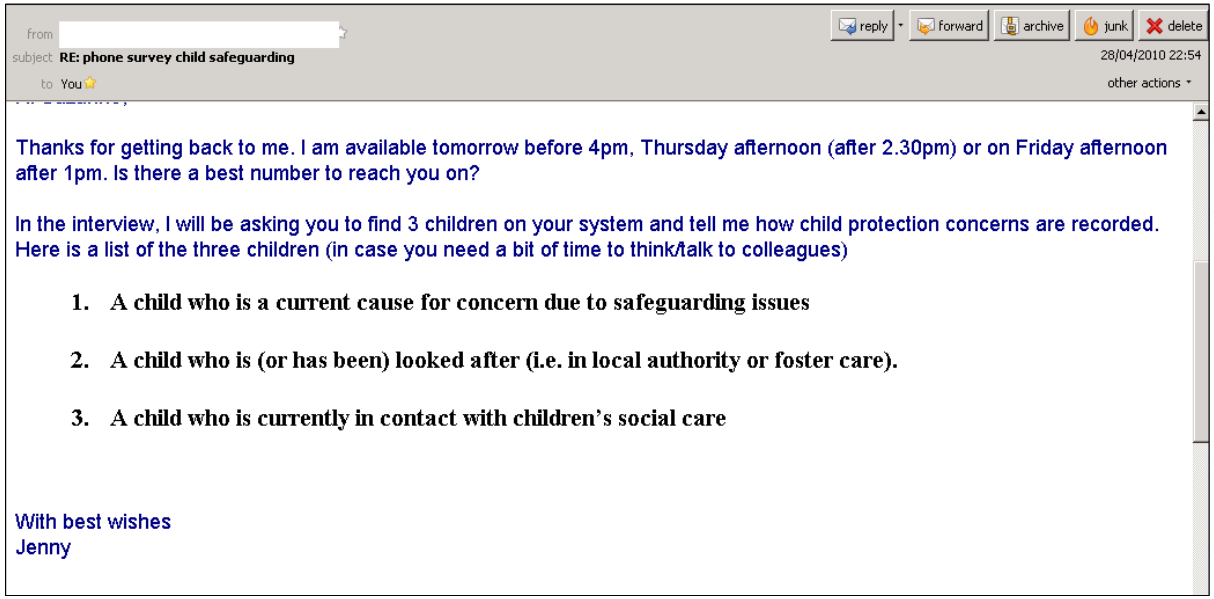
Child protection N=13	Maltreatment N=17	Vulnerable family N=9	Parental problems N=14	Services N=28
Accommodated	Abuse	Concern	Abusive	Agencies
Care order	Abusive	Conflict	Alcohol	agency
Case conference	At risk	Family problem	Drug abuse	Behaviour
Family group conference	Battering	In need	Drug depend	Behavioural
In care	Domestic violence	Psychosocial	Family history	CAHMS
Looked after	Emotional	Social	Father	Community
Protection	Emotional abuse	Unable to cope	Fh*: alcohol	Counselling
Protection plan	Maltreatment	Unable to manage	Fh*: drug	Education
Register	Medical neglect	Vulnerable	Fh*: learning	Health visitor
Removed from home	Neglect		Fh*: mental	Information for
Section 47	Non accidental		Fh*: substance	Information from
Strategy meeting	Non-accidental		Mother	Mental health services
Supervision	Physical abuse		Parent / parents	Midwife
	Psychological		Substance	Nursery
	Sexual abuse			Paediatric
	Victim			Paediatrician
	Violence			Police
				Psychiatric
				Psychiatrist
				Psychologist
				Referred by
				Report
				School
				School nurse
				Social care
				Social services
				Social work
			*Fh=family history	Social worker

Appendix 3.4: List of Read code stems used in second phase of searching V2 5 byte Read code dictionary

Zvu
ZV61
ZV4H
ZV4G
ZV1A
ZV19
ZLD9
ZLD8
ZLD6
ZLA3
ZL64
ZL63
ZL5B
Z41
Z35
SN55
9NN
9NF
9N6
9F2
9EP
8HHB
8H7
64Q
63C
14X
13Z
13W
13V
13I
12X
804
803

Appendix 3.5: Email request for telephone interview

Example email asking GP leads to think of three children with specific child protection characteristics. The wording used to describe the children was kept consistent in all emails



from

subject RE: phone survey child safeguarding

to You

reply | forward | archive | junk | delete

28/04/2010 22:54

other actions

Thanks for getting back to me. I am available tomorrow before 4pm, Thursday afternoon (after 2.30pm) or on Friday afternoon after 1pm. Is there a best number to reach you on?

In the interview, I will be asking you to find 3 children on your system and tell me how child protection concerns are recorded. Here is a list of the three children (in case you need a bit of time to think/talk to colleagues)

1. **A child who is a current cause for concern due to safeguarding issues**
2. **A child who is (or has been) looked after (i.e. in local authority or foster care).**
3. **A child who is currently in contact with children's social care**

With best wishes
Jenny

Appendix 3.6: Report from the workshop with participating GPs, May 2010

Present: Nine GP leads

Apologies: Two GP leads

Format: Each GP presented a case study of a child/family where there were concerns about child maltreatment, followed by open discussion of each case.

Table A3.3 contains a summary of the main points and themes that were discussed. This table was sent to the participating GPs and is the final version that was amended in response to their comments.

Table A3.3: Report from the workshop with participating GPs, May 2010

Issue or question	Details or examples of problem	Possible ways to address issue
Recording maltreatment concerns in the child's records		
What is the purpose of recording safeguarding concerns in GP records?		Recording can flag the child as high risk (including for locums/new GPs); provide detailed narrative description that can be used for e.g. case conference reports; allow GP to give the child/family more consideration.
How can this audit help with recording/better management of these children?	GP recording systems vary greatly.	Solutions need to be quality improvement centric not code centric. Coding should be part of audit and feedback so that it is clearly linked to a purpose.
Can GPs use narrative to indicate concerns?	GP wrote a long text entry about a family which was then used as information for an emergency case conference whilst GP was abroad.	Voice activated typing software could help here with the time constraints of typing (although sometimes this takes just as long or longer). Might be possible to use a 'key phrase' to indicate concerns.
Should GPs be recording observations (rather than concerns)?	Same example as above: GP noted detailed observed parent-child interaction and observed mood of mother in free text notes.	Recording observed behaviour in free text allows recording of 'alleged' concerns (avoids making text sound like 'gossip' and makes it more likely to be taken seriously by children's social care if ever shared).

Table continued overleaf

Table A3.3 *Continued*: report from the workshop with participating GPs, May 2010.

Issue or question	Examples of problem	Possible ways to address issue
Recording maltreatment concerns in the child's records		
Records benefit from knowing who wrote what.	By looking at the name of the person who wrote the note, GP ascertained that it was the health visitor who added the comment, which helped in interpretation of the notes.	Some systems allow each code/note to be marked so that it is clear who entered it (still requires GP to know each professional by name).
No searchable data to find children with safeguarding concerns.	1. A child with a child protection plan did not have any previous codes which meant that he was 'unfindable' on the system without searching for his name. 2. The child protection plan information had been added as text by the health visitor.	1. Some children have no known previous risk and no previous referrals to identify them. The GP can be hesitant to "label" such children. It is good practice to code child Protection plans. 2. 'Hard' information (child protection plan/referrals) can and should be coded. Recording referrals to children's social care or health visitors helps identify those in need as well as those at risk (those children subject to a plan).
Transfer between practices.	If free text or routine codes are recorded in individual consultations these will not be visible unless the GPs scroll back (unlike 'active' or 'significant' problem codes). Potentially this information could be lost.	None mentioned.

Table continued overleaf

Table A3.3 *Continued*: report from the workshop with participating GPs, May 2010.

Issue or question	Examples of problem	Possible ways to address issue
Recording maltreatment concerns in the child's records		
How should Child Protection Reports (child protection plan/case conference) be stored?	There were concerns about how and how long child protection reports should be kept.	RCGP toolkit recommends that the summary page and the case conference report be scanned into the index child's notes (summary into brother, sister and parent's notes). But the reports say that no piece should be taken/read in isolation and some children's social care departments only release the reports on the condition that GPs do not upload them. Some practices scan whole report on to system (but can be difficult to find relevant info quickly). One practice codes children as having had a child protection procedure and then keeps hard copy reports in a filing cabinet that can be referenced. Some concern about whether GPs have a right to store 'non-health' information (e.g. about criminal behaviour) as part of health records.

Table continued overleaf

Table A3.3 *Continued*: report from the workshop with participating GPs, May 2010.

Issue or question	Examples of problem	Possible ways to address the issue
Recording 3rd party information in a child's notes		
Do GPs have easy access to relevant information about family members?	Two siblings had been taken into care but this information was only available in the case conference material for the child in question (i.e. not easily visible on child's/sibling's records). For another case, the mother's notes showed a reasonable level of risk assessment regarding drinking and mental health but there was no mention of mother's problems in child's notes.	One practice uses a white board in reception to identify families that GPs "are concerned about". These families, where possible, are only given appointments with the same doctor. One GP uses a euphemistic code such as "had a chat" in the child's records to alert the GP to parenting concerns (even if there was no "chat" with parents about parenting concerns). Another suggestion at the meeting was to (eventually) develop a risk scoring system for people living at the same address and enter this data on the records of the child/siblings.
How do GPs store information about potential danger posed by non-family members (mother's partner)?	Concerns about male figures in a child's life but felt could not record this -data protection breach for unsubstantiated concerns that cannot later be erased. Concerns about impact of recording if patients request their records might affect family relationships.	GMC advice about this is ambiguous.* *In July 2012 the GMC published new guidance about recording of child maltreatment. It clearly states that both the parent and child's records should contain the concern. It does not provide recommendations regarding third parties who are not the parents.[4]

Table continued overleaf

Table A3.3 *Continued*: report from the workshop with participating GPs, May 2010.

Issue or question	Examples of problem	Possible ways to address the issue
Working with other professionals		
Is the GP aware of health visitor Activity/Concerns?	The health visitor had added notes about targeted visiting and concerns to the child's GP records but saved them in a section of the records which the GP did not use everyday	Systm1 allows health visitors to enter text onto a section of the child's GP records. Other systems and local arrangements do not work so well (The other systems allow it but the health visitors may have to record in three different systems which is too much work). One practice gets a list every month of children targeted by the health visitor which is added to the child's notes by the data entry clerk; another prints out all new children's registrations so that the health visitor can check with the named nurse whether any are subject to a child protection plan.
How to encourage a team based approach within the primary care team?	It was difficult to 'prove' child neglect as it was initially thought to be at the less severe end of the spectrum. The case was managed and monitored for 10 months before children's social care were involved and the child became subject to a child protection plan. It was thought to be significant that the mother had been "in care" herself.	The regular multi-disciplinary (health) team (MDT) meeting, in this case bi-monthly, was used to monitor and manage the case prior to referral to children's social care. The MDTs were seen as a way of managing chronic cases of welfare need in children and families. One GP drew a parallel with MDTs for palliative care, saying these meeting "have revolutionized what we do about palliative care"

Table continued overleaf

Table A3.3 *Continued*: report from the workshop with participating GPs, May 2010.

Issue or question	Examples of problem	Possible ways to address the issue
Working with other professionals		
Information sharing between health visitors and GPs.	The GP only found out about 2 children in care (and not registered with the GP) through the health visitor. The health visitors are often divorced from the practice and use different systems.	MDT meetings are one way of bringing together GPs and health visitors.
Information sharing between GPs and schools.	GP was not informed when the school referred a child to children's social care. If the GP had known about the school concerns this might have prompted an earlier referral from the GP.	GP should know about all referrals as they should be the ones to coordinate care. One GP reported that multidisciplinary team meetings include the school nurse.
Info sharing between GP and children's social care.	Social care rarely seeks information from the GP when the child has been referred by school as a child in need. GPs rarely (never) get feedback from children's social care about referrals/ on-going safeguarding concerns.	One practice fosters relations by offering to host the case conference at the practice (but offer not accepted by children's social care). Should (can?) social workers be part of the MDTs? One GP reported that children's social care had withdrawn from the meetings because the parents were not part of them and consent was thought to be needed.

Table continued overleaf

Table A3.3 *Continued*: report from the workshop with participating GPs, May 2010.

Issue or question	Examples of problem	Possible ways to address the issue
Working with other professionals		
Information sharing between GP and police.	GP was called by Police to do a home visit for a child who had suspected asthma attack. There had been 2 similar Police visits to the family in the previous 10 days (for parental drinking/anti-social behaviour/child unattended) but had not called GP before as child not considered unwell.	There is a system called MERLIN (previously "form 78") run by the Metropolitan Police for children who come to the notice of the Met Police when they attend an incident and whom are considered to be at risk. These children are entered onto a database and in most cases a notification is faxed to children's social care. If education and health agencies have signed up to an information-sharing agreement with the Metropolitan Police, they may also receive MERLIN information. The following events prompt entry on the MERLIN database (not exhaustive list): evidence of prostitution/runaway/subject of prosecution/truanting/victim of crime/arrested (this includes when a child is present when parent/s or carers are arrested)/breach of child curfew/bullying/child care/welfare (including unborn child/a child who is on the child protection register /child found wandering/child with mental health problems/families with mental health issues/domestic violence incidents (regardless of whether child witnessed event). Assessment of parenting capacity is key to understanding the degree of risk, so there is a case for all Merlin reports to be fed back to the GP.

Table continued overleaf

Table A3.3 *Continued*: report from the workshop with participating GPs, May 2010.

Issue or question	Examples of problem	Possible ways to address the issue
The role of the GP		
What about the transition to adulthood for vulnerable children?	The GP rang the named nurse to see if a16 year old girl was on a child protection plan. She wasn't but he later found out she was subject to a 'sexual exploitation protocol' (This is a child in need category – section 17 rather than 47). She had previously been subject to a child protection plan but this was not coded in the notes.	There is a strong case for coding those subject to "sexual exploitation protocol" or child in need, as these are a particularly vulnerable group of young people. GPs do not usually receive this information from the LSCB or the police. It needs to be clear from the notes whether a child has a previous child protection plan as the problems can be chronic. Children's social care may destroy their own notes after 5 years so it is even more important that GPs have a record as problems can persist beyond this and can be intergenerational.
Ability to act is limited by difficulties of being proactive for children >5 years.	Health visitor can be sent out to children <5 years (if resources permit) but not for the older children.	Gathering information about older children is more difficult for the GP than younger ones.
Ability to act being limited by child and parental co-operation with further investigation.	GP had been told by a 14 year old of a serious incident when his father had tried to harm him. He was subsequently persuaded by the rest of the family to withdraw his statement and no further action was possible.	GPs can be an advocate for children but even this can be limited by factors outside their control. There needs to be more detail in A&E reports to the GP – such as "non accidental injury excluded."

Table continued overleaf

Table A3.3 *Continued*: report from the workshop with participating GPs, May 2010.

Issue or question	Examples of problem	Possible ways to address the issue
The role of the GP		
What can GPs do for children who give rise to safeguarding concerns (either prior to or alongside formal children's social care child protection/ child in need procedures)?	None mentioned.	GPs are one of the universal services and can provide continuity between practices and sectors and different members of the same family. GPs can be advocate for child at case conference and child protection plan meetings because they are used to collating and analysing information about children and families. GPs can have a 'coaching role' for parents to encourage good parenting and health seeking behavior. GPs can play a monitoring role and have opportunity for repeated observations and flagging up concerns. GPs can offer support through building a therapeutic relationship with patients which creates a narrative. However, GPs need a community support system (health visitors, nurses, local services) to help them and, as always, there are massively time restraints. The authorities locally are "hamstrung" with funding restrictions despite statutory duties. Auditing process rather than outcome is valid for this audit.

Appendix 3.7: Results from telephone interviews: recording practice for three case examples

GP lead♠	Type of concern and relevant† Read codes noted in records			Additional information
	Child Type A: cause for concern	Child Type B: Looked After	Child Type C: social care contact	
1.	**13IS.00** Child in need. **9FX..00** Child exam-NOS. **13IF.00** Child at risk. **8HHB.00** Referral to social services. **9N32.00** Third party encounter. **16B..00** Bruising symptom.	**3875.00** Social services case conference. **13VF.00** At risk violence in the home. **13Ie.00** Child on supervision order. **ZU…00** Family details and household composition code. **13If.00** child is cause for concern.	**13Iv.00 S**ubject to child protection plan. **9N32.00** Third party encounter. **13IM.00** Child protection register. **13ZT.00** At risk of physical abuse. **1283.00** Fh (family history): drug dependency. **13Iw.00** No longer subject to child protection plan.	Child A had extensive free text comments about bruising, third party encounter (paediatrician) and referral to Social Care. Child A had child protection concerns as a 'priority 1' entry. Child C had extensive free text notes. Priority 1 coding used instead of an alert system.
2.	**YO3d2 C**hild is cause for concern. **XM07a** Failure to thrive **Ya8O4** Child subject to child protection plan.	**YO4b3** Child Looked After. **XE2v2** Childhood autism.	**XaIO8** Child in need. **E2Fz.** Developmental disorder. **Ub1UQ** Developmental language delay.	Child A had an alert on the home page with reminder of child protection plan and supervision order and advice to report concerns to safeguarding lead. Routine reminders for all children subject to a child protection plan or children with recurrent episodes of need (but not Looked After children).

Table continued overleaf

Appendix 3.7 *Continued*: results from telephone interview: recording practice for three case examples

GP lead♠	Type of concern and relevant† Read codes noted in records			Additional information
	Child Type A: cause for concern	Child Type B: Looked After	Child Type C: social care contact	
3.	GP lead not interviewed.			
4.	**13VF.00** At risk violence in the home. **13G2.00** Health visitor visits. **918L.00** Carer - mobile telephone number.	No child identified by GP.	**XaIO8** Child in need. **XE2v6** Child at risk – case conference. **Y3771** Social worker assigned. **Ya804** Child protection register. **Ya433** Child protection administration. **XaF81** Did not attend hospital appointment. **X70xw** Child neglect. **Ub0eb** Child health plan. **Ya619** Child protection report submitted. **Ub0F2** Child taken into care.	Child A had a major alert on the home page detailing enhanced health visiting services and comments from health visitor. Child C had extensive free text notes.

Table continued overleaf

Appendix 3.7 *Continued*: results from telephone interview: recording practice for three case examples

GP lead♠	Type of concern and relevant† Read codes noted in records			Additional information
	Child Type A: cause for concern	Child Type B: Looked After	Child Type C: social care contact	
5.	**13IM.00** Child protection register. **64c..00** Child protection procedure. **ZV4H300** Emotional neglect of child. **14X7.00** Victim of emotional abuse. **8CM6.00** Child protection plan. **Eu9..00** Emotional/ behavioural problems. **13G4.00** Social worker.	**13IB.00** Child in foster care.	**U3…11 [**X]NAI - Non accidental injury. **13IO.00** Child removed from protection register.	Child A had a major alert related to child protection plan.
6.	GP lead not interviewed.			
7.	No relevant Read codes.	**13IB.00** Child in foster care.	No relevant Read codes.	All children had extensive free text entries.

Table continued overleaf

Appendix 3.7 *Continued*: results from telephone interview: recording practice for three case examples

GP lead♠	Type of concern and relevant† Read codes noted in records			Additional information
	Child Type A: cause for concern	Child Type B: Looked After	Child Type C: social care contact	
8.	No relevant Read codes.	No child identified.	No relevant Read codes.	Child A had a letter from children's social care scanned into notes. Child C had child protection information stored in a folder in the practice manager's room and scanned records of A&E attendances for injury in notes.
9.	**Z352.00** Child protection investigation. **13IF.00** Child at risk. **13IO.00** Child removed from protection register. **13IM.00** Child protection register.	**13IV.00** Looked after child - Children (Scotland) Act 1995. **9….00*** Administrative code with 'Looked After Child' as a free text entry.	**6405*** Child on protection register.	Child A had extensive free text comments attached to the codes. Child C had correspondence from Social Care attached to the notes.
10.	**8CM6.00** Child protection plan.	**13IB.00** Child in foster care. **EMISNQSA3**** Safeguarding code.	**64c..00** Child protection procedure. **8CM6.00** Child protection plan. **EMISNQSA3**** Safeguarding code.	All three children had extensive free text comments related to safeguarding, including who was with the child at consultation. Child C had a 'major alert'.

Table continued overleaf

Appendix 3.7 *Continued*: results from telephone interview: recording practice for three case examples

GP lead♠	Type of concern and relevant† Read codes noted in records			Additional information
	Child Type A: cause for concern	Child Type B: Looked After	Child Type C: social care contact	
11.	No relevant Read codes.	No relevant Read codes.	**16B..00** Bruising symptom.	Child A had extensive free text notes including information about child protection plan and social worker. Child B's note contained a child protection plan. Child C's notes contained a letter from outside agency and child protection plan review documents.

♠ Number corresponds to site ID in Table 3-2 (Chapter 3).
† Judged to be relevant to child safeguarding by the participating GP.
*These codes are erroneous (interviewer/interviewee error). They are incorrect format for Version 2 codes and not found in any dictionary.
** Codes starting with 'EMIS' are practice specific codes using EMIS software.

Appendix 3.8: Complete list of Read codes used to measure recorded maltreatment-related concerns, grouped by the four sub-categories of code and sub-concepts

Concept	Read code	Description
1. Child protection procedures N=24		
Child protection plan N=9.	13IC.00	At risk register.
	13ICZ00	At risk regist NOS.
	13IM.00	Child on protection register.
	13Id.00	On child protection register.
	13Iv.00	Subject to child protection plan.
	8CM6.00	Child protection plan.
	Z331.00	Child protection plan.
	Z331100	Intra-agency protection plan.
	Z351.00	Immediate protection of child.
Case conference N=10.	3874.00	Multidisciplinary case conference.
	3875.00	Social services case conference.
	9F2..00	Child at risk-case conference.
	9F2..11	Risk child case conf admin.
	9F21.00	Child at risk conf attend >1hr.
	9F22.00	Child at risk conf attend <1hr.
	9F23.00	Child at risk conf fee to SS.
	9F24.00	Child at risk conf fee paid.
	9F25.00	Child at risk fee unpaid.
	9F2Z.00	Child at risk case conf NOS.
Unspecified child protection procedure and investigation N=5.	64c..00	Child protection procedure.
	Z35..00	Child protection procedure.
	Z352.00	Child protection investigation.
	Z352.11	Child abuse investigation.
	ZH11900	Surveillance for child protection.

Table continued overleaf

Appendix 3.8 *Continued*: complete list of Read codes used to measure recorded maltreatment-related concerns

Concept	Read code	Description
2. Direct references to maltreatment and out-of-home care N=129		
Looked after child N=28.	1338.00	Fostered.
	13I9.00	Fostering of child.
	13IB.00	Child in care.
	13IB000	Child in foster care.
	13IJ.00	Institutionalised childhood.
	13IV.00	Looked after child - Children (Scotland) Act 1995.
	13Ie.00	Child on supervision order.
	13Ih.00	Subject to supervision order under Children Act 1989.
	13Ii.00	Subject to care order under Children Act 1989.
	13Ij.00	Subject to interim care order under Children Act 1989.
	13Ik.00	Child in care voluntarily.
	13Il.00	Subject to interim supervision order under Children Act 1989.
	13VJ.00	In care.
	38C0.00	Child in care health assessment.
	6982.00	Fostering medical examination.
	6A50.00	Child in care statutory review meeting
	8GE7.00	Foster care.
	9ET..00	NA52-Magistrate's care order.
	9ET1.00	NA52 care order completed.
	9ETZ.00	NA52 - care order NOS.
	9F3..00	Child into care examination.
	9F3..11	Care: child into - exam admin.
	Z314.11	Parental responsibility transferred to adoption agency.
	Z353.00	Provision of accommodation.
	Z353100	Child accommodated.
	Z353111	Entry into accommodation.
	Z353200	Child taken into care.
	ZV4G100	[V]Removal from home in childhood.
Family child protection plan N=3.	13IN.00	Family member on protection register.
	13Ig.00	Family member on child protection register.
	13Iy.00	Fam mem sub child protect plan.

Table continued overleaf

Appendix 3.8 *Continued*: complete list of Read codes used to measure recorded maltreatment-related concerns

Concept	Read code	Description
2. Direct references to maltreatment and out-of-home care *continued* N=129		
Physical abuse (named) N=34.	12Z2.11	FH*: Child battering.
	13VF.00	At risk violence in the home.
	13ZT.00	At risk of physical abuse.
	14X5.00	Victim of physical abuse.
	63CB.00	Risk of non-accidental injury.
	Eu6y200	[X]Munchausen's by proxy.
	R00zA00	[D]Physical violence.
	SN55200	Non-accidental injury to child.
	SN55211	NAI - non-accidental injury to child.
	SN55300	Battered baby or child syndrome NOS.
	SN55311	Battered baby syndrome NOS.
	SN55312	Battered child syndrome NOS.
	SN55500	Physical abuse of child.
	SyuF.00	[X]Poisoning by drugs and biological substances.
	SyuFc00	[X]Poisoning by oth & unspecif drugs & biological substances.
	TL7..00	Child battering and other maltreatment.
	TL70.00	Child battering or other maltreatment by parent.
	TL7y.00	Child battering or other maltreatment by other spec person.
	TL7z.00	Child battering or other maltreatment by person NOS.
	TN0..00	Injury ?accidental poisoning by solid/liquid substances.
	TN06.00	Injury ?accidental poisoning by corrosive/caustic substance.
	TN87.00	Injury ?accidental by caustic substances except poisoning.
	U3...11	[X]NAI - Non accidental injury.
	U30..00	[X]Assault by drugs medicaments and biological substances.
	U31..00	[X]Assault by corrosive substance.
	U310.00	[X]Assault by corrosive substance occurrence at home.

Table continued overleaf

Appendix 3.8 *Continued*: complete list of Read codes used to measure recorded maltreatment-related concerns

Concept	Read code	Description
2. Direct references to maltreatment and out-of-home care *continued* N=129		
Physical abuse (named) cont.	U31z.00	[X]Assault by corrosive substance occurrn at unspecif place.
	U35..00	[X]Assault by unspecified chemical or noxious substance.
	U350.00	[X]Assault by unspecif chemical/noxious substance occ home.
	U36..12	[X]Smothered / suffocated.
	U3H..00	[X]Assault by pushing / placing victim before moving object.
	ZI44200	Smothering.
	ZV4G500	[V]Problems related to alleged physical abuse of child.
	ZV61211	[V]Child battering.
Emotional abuse (named) - including parental domestic violence N=8.	13HP600	Violence between parents.
	13ZR.00	At risk of emotional/psychological abuse.
	14X7.00	Victim of emotional abuse.
	14X8.00	Victim of domestic violence.
	SN55000	Emotional maltreatment of child.
	SN55011	Emotional deprivation of child.
	SN55012	Emotional abuse of child.
	ZV4H300	[V]Emotional neglect of child.
Neglect N=17.	13ZV.00	At risk of neglect by others.
	SN55100	Nutritional maltreatment of child.
	SN55111	Nutritional deprivation of child.
	SN55112	Malnutrition in child maltreatment syndrome.
	SN55z13	Neglect affecting child NEC.
	SN57000	Neglect or abandonment.
	TE40100	Accident due to neglect of newborn.
	TLx4.00	Assault by criminal neglect.
	U3M..00	[X]Neglect and abandonment.
	U3M0.00	[X]Neglect and abandonment by spouse or partner.
	U3M1.00	[X]Neglect and abandonment by parent.
	U3M2.00	[X]Neglect and abandonment by acquaintance .
	U3My.00	[X]Neglect and abandonment by other specified persons.

Table continued overleaf

Appendix 3.8 *Continued*: complete list of Read codes used to measure recorded maltreatment-related concerns

Concept	Read code	Description
2. Direct references to maltreatment and out-of-home care *continued* N=129		
Neglect cont.	U3Mz.00	[X]Neglect and abandonment by unspecified person.
	ZV4H400	[V]Other problems related to neglect in upbringing.
	ZV61212	[V]Child neglect.
	ZVu4B00	[X]Other problems related to neglect in upbringing.
Sexual abuse (named) N=6.	13WC.00	Incest.
	13ZW.00	At risk of sexual abuse.
	14X6.00	Victim of sexual abuse.
	SN57100	Sexual abuse.
	ZV4F900	[V]Probs rel alleg sex abuse child by pers out prim sup grp.
	ZV4G400	[V]Problem relatd/alleg sex abuse cld by person prim sup grp.
Prenatal abuse N=15.	1282.1	Alcoholic offspring.
	L183.00	Drug dependence in pregnancy childbirth and the puerperium.
	L183.11	Pregnancy and drug dependence.
	L183000	Drug dependence - unspec whether during pregnancy/puerperium.
	L183100	Drug dependence during pregnancy - baby delivered.
	L183200	Drug dependence in the puerperium - baby delivered.
	L183300	Drug dependence during pregnancy - baby not yet delivered.
	L183400	Drug dependence in puerperium - baby previously delivered.
	L183z00	Drug dependence during pregnancy/childbirth/puerperium NOS.
	L254.11	Suspect fetal damage from maternal alcohol.
	L255300	Maternal care for (suspected) damage to fetus from alcohol.
	PK80.00	Fetal alcohol syndrome.
	PK83.00	Fetus and newborn affected by maternal use of alcohol.

Table continued overleaf

Appendix 3.8 *Continued*: complete list of Read codes used to measure recorded maltreatment-related concerns

Concept	Read code	Description
2. Direct references to maltreatment and out-of-home care *continued* N=129		
Prenatal abuse cont.	Q007100	Fetus/neonate affected by placental/breast transfer alcohol.
	Q007111	Fetal alcohol syndrome.
Type of maltreatment not specified N=13.	1J3..00	Suspected child abuse.
	SN55.00	Child maltreatment syndrome.
	SN55z00	Child maltreatment syndrome NOS.
	SN55z11	Child abuse NEC.
	SN57.00	Maltreatment syndromes.
	SyuH500	[X]Other maltreatment syndromes.
	U3N..00	[X]Other maltreatment syndromes.
	U3N1.00	[X]Other maltreatment syndromes by parent.
	U3N2.00	[X]Other maltreatment syndromes by acquaintance or friend.
	U3N3.00	[X]Other maltreatment syndromes by official authorities.
	U3Ny.00	[X]Other maltreatment syndromes by other specified persons.
	U3Nz.00	[X]Other maltreatment syndromes by unspecified person.
	ZV61200	[V]Child abuse.
Counselling for maltreatment N=5.	Z41..00	Abuse counselling.
	Z411.00	Sexual abuse counselling.
	Z412.00	Physical abuse counselling.
	Z413.00	Verbal abuse counselling.
	Z4L..00	Psychological abuse counselling.
3. High risk child N=131		
Child in Need Plan.	8CM5.00	Child in need plan.
History of physical abuse in family N=4..	14X0.00	History of physical abuse.
	63C4.00	Battered baby suspect – FH.*
	ZV19C00	[V]Family history of physical abuse to sibling.
	ZV19D00	[V]FH* physical abuse to sibling by family member.
History of sexual abuse in family N=3	14X1.00	History of sexual abuse.
	ZV19E00	[V]Family history of sexual abuse to sibling.
	ZV19F00	[V]FH* of sexual abuse to sibling by family member.

Table continued overleaf

Appendix 3.8 *Continued*: complete list of Read codes used to measure recorded maltreatment-related concerns

Concept	Read code	Description
3. High risk child *continued* N=131		
Hist. dom. violence N=2.	14X3.00	History of domestic violence.
	14XD.00	History of domestic abuse.
History of maltreatment in family (type unspecified) N=5.	13W3.00	Child abuse in family.
	14X..00	History of abuse.
	6254.00	A/N care: H/O child abuse.
	ZV19J00	[V]Family history of sibling abuse NOS.
	ZV19K00	[V]Family history of sibling abuse by family member NOS.
Hist emotional abuse in family N=3.	14X2.00	History of emotional abuse.
	ZV19G00	[V]Family history of mental abuse to sibling.
	ZV19H00	[V]FH*of mental abuse to sibling by family member.
Child does not live with parents (no mention of statutory processes) N=7.	13IK.00	Child lives with grandparents.
	13Ic.00	Child lives with another relative.
	13Is.00	Lives with grandfather.
	13It.00	Lives with grandmother.
	13Iu.00	Child living with unrelated adult.
	ZU33700	Lives with grandparents.
	ZU33900	Lives with grandmother.
Indirect references to maltreatment (euphemistic) N=59.	13IF.00	Child at risk.
	13IF.11	Vulnerable child.
	13II.00	Child deserted by parents.
	13II.11	Child deserted by mother.
	13IQ.00	Vulnerable child in family.
	13IS.00	Child in need.
	13If.00	Child is cause for concern.
	13Ip.00	Family is cause for concern.
	13Iq.00	Vulnerable family.
	13VE.00	At risk accident in home.
	13W4.00	Parent/child conflict.
	13W4000	Child/parent violence.
	1BE1.00	Problem situation.
	625..00	A/N care: social risk.
	625Z.00	A/N care: social risk NOS.

Table continued overleaf

Appendix 3.8 *Continued*: complete list of Read codes used to measure recorded maltreatment-related concerns

Concept	Read code	Description
3. High risk child *continued* N=131		
Indirect references to maltreatment (cont.)	63C..00	At-risk factors.
	63C2.00	Bonding problems.
	63CD.00	High risk infant.
	63CZ.00	at-risk factors NOS.
	E2Dz.11	Overprotective parent.
	SN55400	Multiple deprivation of child.
	SN55z12	Child deprivation syndrome.
	U40..00	[X]Poisoning/expos noxious subst undetermined intent.
	ZU27200	Deserted by parents.
	ZU27300	Deserted by father.
	ZU27400	Deserted by mother.
	ZV23800	[V]Supervision of high-risk pregnancy - social problems.
	ZV4F.00	[V]Problems related to social environment.
	ZV4F400	[V]Inadequate family support.
	ZV4G.00	[V]Problems related to negative life events in childhood.
	ZV4G300	[V]Events resulting in loss of self-esteem in childhood.
	ZV4G600	[V]Personal frightening experience in childhood.
	ZV4Gy00	[V]Other negative life events in childhood.
	ZV4H.00	[V]Other problems related to upbringing.
	ZV4H000	[V]Inadequate parental supervision and control.
	ZV4H100	[V]Parental overprotection.
	ZV4H200	[V]Hostility towards and scapegoating of child.
	ZV4H500	[V]Inappropriat parental press+oth abn qualities/upbringing.
	ZV4H600	[V]Lack of learning and play experience.
	ZV4Hy00	[V]Other specified problems related to upbringing.
	ZV4J.00	[V]Problems related to certain psychosocial circumstances.
	ZV60400	[V]No able carer in household.
	ZV60800	[V]Carer unable to cope.
	ZV60y00	[V]Other social reason for encounter.

Table continued overleaf

Appendix 3.8 *Continued*: complete list of Read codes used to measure recorded maltreatment-related concerns

Concept	Read code	Description
3. High risk child *continued* N=131		
Indirect references to maltreatment (cont.)	ZV61.00	[V]Other family reason for encounter.
	ZV61000	[V]Family disruption.
	ZV61213	[V]Parent - child conflict.
	ZV61300	[V]Other parent-child problems.
	ZV62.00	[V]Other psychosocial circumstances.
	ZVu4900	[X]Other problems related to social environment.
	ZVu4A00	[X]Other negative life events in childhood.
	ZVu4C00	[X]Inapprop parental pressure & oth abnorm quals upbringing.
	ZVu4D00	[X]Other specified problems related to upbringing.
	ZVu4E00	[X]Other stressful life events affecting family & household.
	ZVu4F00	[X]Other specif problems related to primary support group.
	ZVu4G00	[X]Other specif problems rel to psychosocial circumstances.
	ZVu4H00	[X]Problem related to unspecif psychosocial circumstances.
	ZVu4J00	[X]Negative life event in childhood unspecified.
	ZVu5400	[X]Other problems related to care provider dependency.
Parental risk factors N=20.	1282.00	FH*: Alcoholism.
	1282.1	Alcoholic in the family.
	1283.00	FH*: Drug dependency.
	12W1.00	Family history of learning difficulties.
	12W2.00	Family history of learning disability.
	12X..00	Family history of substance misuse.
	12X0.00	Family history of alcohol misuse.
	12X1.00	Both parents misuse drugs.
	12X2.00	Paternal drug misuse.
	63C6.00	Maternal drug abuse.
	63C6.11	Maternal drug misuse.
	63C7.00	Maternal alcohol abuse.
	ZV17000	[V]Family history of psychiatric condition.

Table continued overleaf

Appendix 3.8 *Continued*: complete list of Read codes used to measure recorded maltreatment-related concerns

Concept	Read code	Description
3. High risk child *continued* N=131		
Parental risk factors cont.	ZV1A.00	[V]Family history of mental and behavioural disorders.
	ZV1A000	[V]Family history of alcohol abuse.
	ZV1A200	[V]Family history of other mental and behavioural Disorders.
	ZV1A300	[V]Maternal family history of drug addiction.
	ZV61511	[V]Alcoholism in family.
	ZVu6300	[X]Family history of other psychoactive substance.
	ZVu6400	[X]Family history of other substance abuse.
Difficult family circum-stance N=8.	13W..11	Family problems.
	13W5.11	Disturbed family.
	13WG.00	Disturbed childhood.
	13Z4A00	Early admission to school for social reasons.
	13Z8.00	Social problem.
	13Z8100	Poor social circumstances.
	63CA.00	H.V.: mother not managing well.
	ZVu4700	[X]Other problems related to physical environm.
Family needs or is receiving support N=19.	62D2.00	Parent craft class not offered.
	62D4.00	Parent craft class attended.
	62D5.00	Parent craft -individual class.
	62D6.00	Parent craft - group class.
	62DZ.00	Parent craft class NOS.
	6B2..00	Sure Start programme.
	6B20.00	Sure Start registered.
	8GC..00	Voluntary social agency.
	8O3..00	Long term social support.
	8O4..00	Vulnerable family support.
	8O82.00	Emotional and psychosocial support and advice.
	Z5B1.00	Therapeutic community approach.
	Z7A6.00	Parenting skills training.
	Z9M2.00	Parental support.
	Z9M7.00	Emotional support.
	Z9M7.11	Psychological support.
	Z9MM.00	Social support.
	Z9MN.00	Long term social support.

Table continued overleaf

Appendix 3.8 *Continued*: complete list of Read codes used to measure recorded maltreatment-related concerns

Concept	Read code	Description
4. Contact with social care (not specified as child protection) N=66		
Referral to social care N=11.	64RA.00	Child: social services.
	64RA.11	Child referral-social services.
	8H75.00	Refer to social worker.
	8H7y.00	Referral to housing department.
	8H7z.00	Referral to disablement services.
	8HHB.00	Referral to Social Services.
	ZL79.00	Referral to social worker.
	ZL79.11	Refer to social worker.
	ZL79100	Referral to social services department social worker.
	ZL79111	Referral to SSD social worker.
	ZL79200	Referral to social services department care manager.
Ref from social care.	9N67.00	Referred by social worker.
In contact with social care services N=54.	13G4.00	Social worker involved.
	63C9.00	Mother has a social worker.
	6735.00	Counselled by a social worker.
	8GB..00	Social case work.
	8GB1.00	Medical social worker involved.
	8GBZ.00	Social case work NOS.
	8GE..00	Social care.
	8GEZ.00	Other social care NOS.
	9H12.00	Form 4 passed to social worker.
	9H42.00	Form 2 passed to social worker.
	9H52.00	Form 3 passed to social worker.
	9N26.00	Seen by social worker.
	9NDA.00	Report received from social services.
	9NN3.00	Has support worker.
	9NNV.00	Under care of social services.
	9Nl6.00	Seen by social services.
	9b0k.00	Social services report.
	ZK...00	Social services procedures.
	ZK1..00	Social work support.
	ZK1..11	Social services professional support.
	ZK11.00	Support from social services care manager.
	ZK2..00	Screening by social services department.

Table continued overleaf

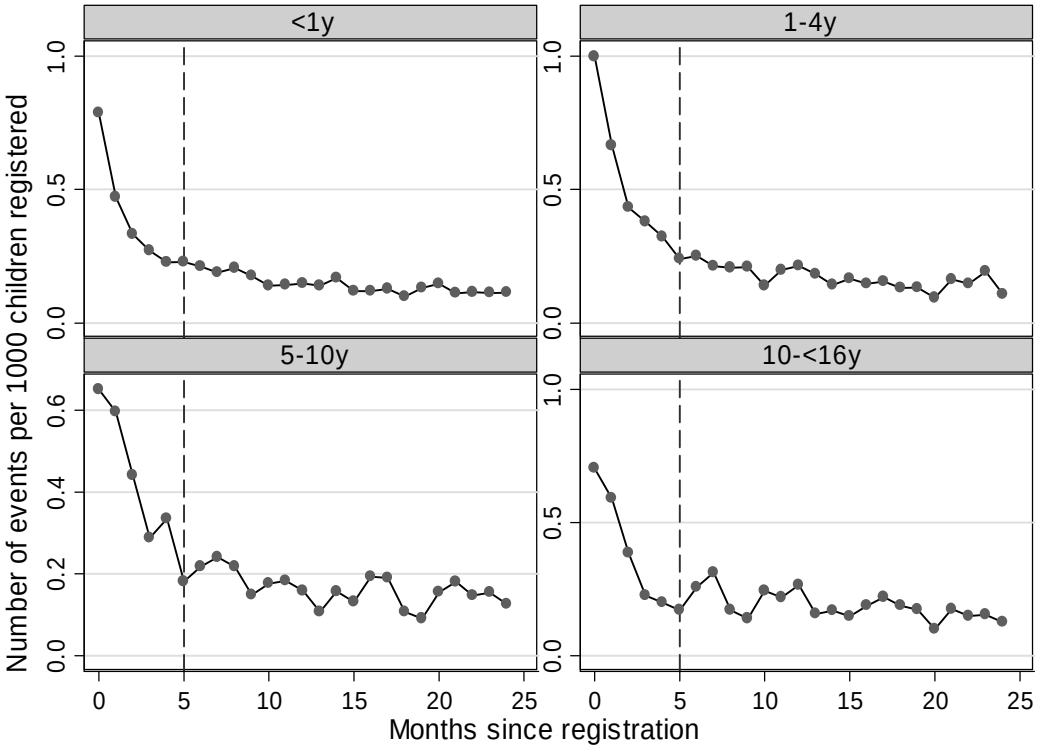
Appendix 3.8 *Continued*: complete list of Read codes used to measure recorded maltreatment-related concerns

Concept	Read code	Description
4. Contact with social care (not specified as child protection) N=66		
	ZK2..11	Filtering by social services department.
	ZK2..12	Social services contact screening.
	ZK3..00	SSD ref furth soc serv assessm.
	ZK4..00	Social services client assessment.
	ZK4..11	Social services needs assessment.
	ZK41.00	Social services client reassessment.
	ZK41.11	Social services needs reassessment.
	ZK42.00	Social services full assessment.
	ZK43.00	Social services specialist assessment.
	ZK44.00	Social services financial assessment.
	ZK45.00	Social services simple assessment.
	ZK46.00	Social services complex assessment.
	ZK5..00	Social services care planning.
	ZK51.00	Agreeing on social services care plan.
	ZK52.00	Producing social services care plan.
	ZK53.00	Sending client copy of social services care plan.
	ZK53100	Snd client cpy rvsd SSD carpel.
	ZK6..00	Social services care package procedure.
	ZK61.00	Negotiating social services care package.
	ZK62.00	Social services care package review.
	ZK62100	Social services care package scheduled review.
	ZK62200	Social services care package unscheduled review.
	ZK63.00	Provision of social services care package.
	ZK63100	Provision of residential social services care package.
	ZK63200	Provision of social services community based care package.
	ZK63300	Provision of revised social services care package.
	ZK7..00	Provision of basic social service.
	ZK7..11	Provision of simple social service.
	ZK7..12	Provision of one-off social service.
	ZK77.00	Provision of social worker time for client.
	ZLB8.00	Seen by social services department care manager.
	ZLB9.00	Seen by social services department duty staff.
*FH=family history		

APPENDIX 4: Supplementary material for Chapter 4

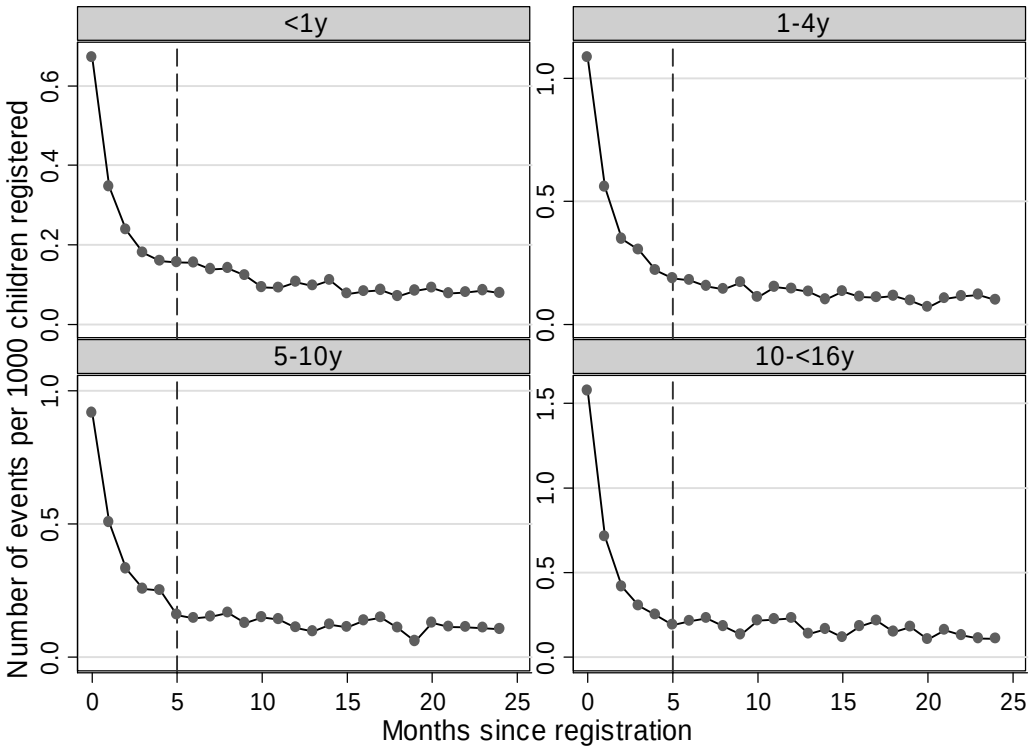
Appendix 4.1 Plot of maltreatment-related events against time since registration, by subgroup of maltreatment-related codes and age-group at registration

A: codes relating to child protection procedures.



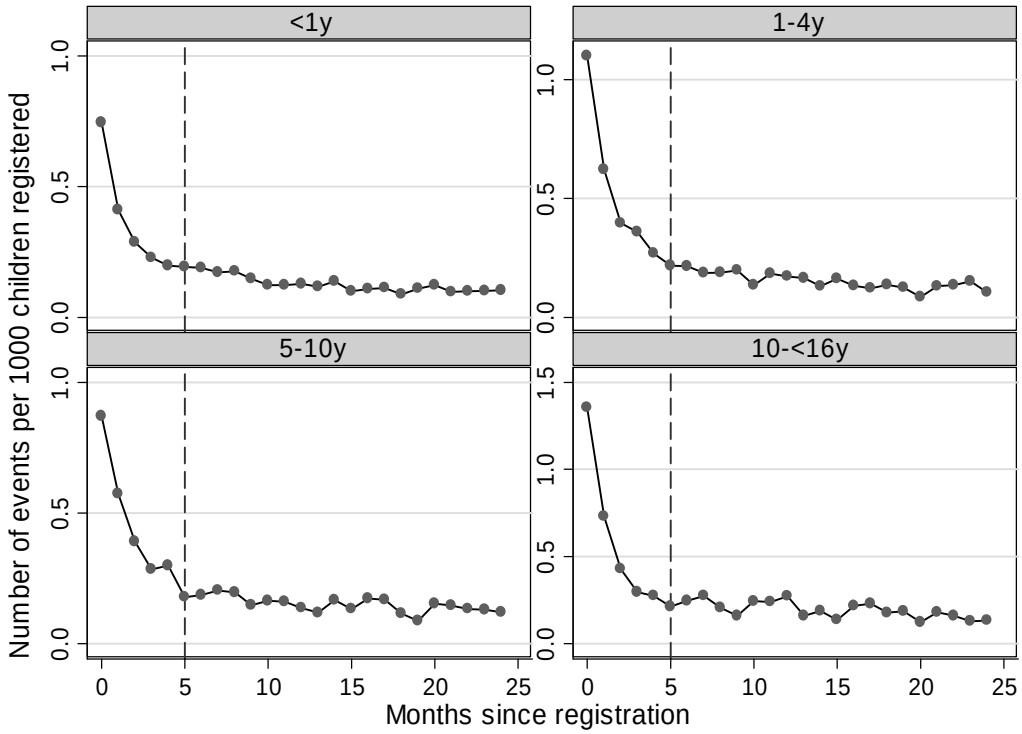
Vertical line represents 5 month cut-off for time-at-risk (not applied to infants)

B: Codes making direct reference to maltreatment or out-of-home care.



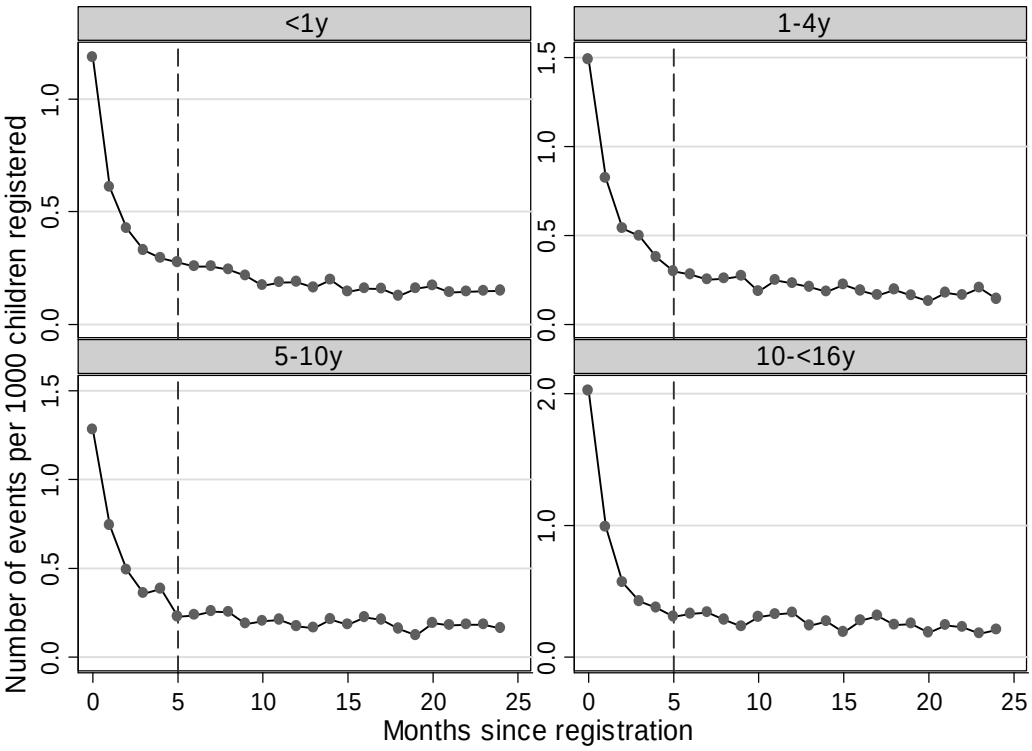
Vertical line represents 5 month cut-off for time-at-risk (not applied to infants)

C: Codes signalling ‘high risk’ child.



Vertical line represents 5 month cut-off for time-at-risk (not applied to infants)

D: Codes relating to involvement with children's social care.



Vertical line represents 5 month cut-off for time-at-risk (not applied to infants)

Appendix 4.2: AIC scores for 13 models tested during model selection

	Any MR code	CP	Direct ref	High risk	CSC
	Akaike's information criterion (AIC) scores				
Fit of Poission distribution with a linear trend, adjusting for socio-demographic variables + interaction term*					
Model 1: Poisson linear trend, unadjusted	239368.5	127292.4	62210.6	123667.5	51296.9
Model 2: model 1 + adj for sex	239261.0	127291.4	62211.0	123469.3	51293.5
Model 3: model 2 + adj for ageband	232376.2	122693.1	61193.2	119576.3	50997.3
Model 4: model 3 + adj for deprivation	215803.4	111577.3	59634.7	114812.9	49017.2
Model 5: model 4 + interaction*	215634.0	111551.1	59591.2	114777.2	49008.2
Poisson versus negative binominal distribution (no random intercept term)					
Model 6: nb** linear trend adj for sex, ageband, deprivation + interaction * Test if alpha=0 X^2= 3.3e+04 *p*=<0.000 (i.e. evidence of overdispersion and reason to use a negative binomial distribution)‡					
Test adjusted linear, log linear and 2005 change-point modelsl + interaction term using a negative binominal distribution +/- random intercept					
Model 7: nb** linear trend, adj for sex, ageband, deprivation + interaction*	197557.7	106812.6	56575.5	91496.40	46279.17
Model 8: model 7 + random intercept term	178842.9	98712.0	53400.2	76266.1	41360.1
Model 9: nb** log linear trend, adj for sex, ageband, townsend + interaction*	197374.9	106638.6	56491.2	91522.32	46225.00
Model 10: model 9 + random intercept term	178517.1	98578.1	53339.3	76199.4	41316.6
Model 11: nb** model + 2005 change, adj for sex, ageband, townsend + interaction*	197434.4	106693.8	56469.3	91469.70	46223.44
Model 12: model 11 + random intercept term	178687.0	98657.6	53358.9	76180.8	41320.2
Test that the best performing model (model 10) should include interaction term*					
Model 13: model 10 without interaction*	178638.3	98601.0	53378.4	76193.62	41318.80

* Fitted interaction is between age and deprivation categories; ** nb=negative binomial distribution; ♠ MR=maltreatment-related; CP=child protection procedure; Direct ref=direct references to maltreatment/out-of-home care; CSC=contact with children's social care. ‡ This test is included in the output from the STATA command "nbreg".

Appendix 4.3: Ethics approval for THIN study

SRC Feedback

Researcher Name: Dr Irene Petersen
Organisation: UCL
SRC Reference Number: 11-011
Date: 17/05/2011
Study title: Recording of child maltreatment in primary healthcare settings in the UK: a study using The Health Improvement Network (THIN) database.
Committee opinion: Approved

The following feedback has been supplied by the SRC.

Notes from the Chair:

Advice (General advice for the researchers as information only)
Have the researchers considered using the FAMNUM code to look at family factors as well. This will need some work on and may be reliable only for a subset but might add additional insights

---

We are pleased to inform that you can proceed with the study as this is now approved.

Once the study has been completed and published, you must let CSD Medical Research know in order for your reference number to be closed.

CSD Medical Research will let the relevant Ethics committee know this study has been approved by the SRC and will inform them of study completion (when known) on your behalf.

I wish you and your team all the best with the study progression.

Kind Regards,

Mustafa Dungarwalla
Research Associate

Appendix 4.4: Characteristics of subset of data for children registered 2008-2010.

	2008-2010 443 practices contributed data♠		
	Children ≥1 maltreatment-related code	**All children**	**Years at risk**
	N (%)		Sum (median)
All children	14,441 (1.5)	955,267 (100.0)	2,068,974.4 (2.8)
Boy	7,077 (49.0)	489, 361 (51.2)	1.060,032.1 (2.8)
Girl	7,364 (51.0)	465, 906 (48.8)	1,008,942.3 (2.8)
<1y*	3, 853 (26.7)	170,290 (17.8)	271,237 (1.5)
1-4y*	3,595 (24.9)	189,036 (19.8)	445,507 (3.0)
5-9y*	3,123 (21.6)	218,014 (22.8)	550,581 (3.0)
10-15y*	3,447 (23.9)	282,827 (29.6)	713,482 (3.0)
16-17y*	423 (2.9)	95,100 (10.0)	88,167 (0.5)
Least deprived quintile†	1,470 (10.5)	228,025 (24.6)	523,542 (3.0)
2†	1,531 (11.0)	187,823 (20.2)	418,232 (3.0)
3†	2,704 (19.4)	192,103 (20.7)	412,788 (2.7)
4†	3,964 (28.4)	183,669 (19.8)	382,596 (2.5)
Most deprived quintile†	4,283 (30.7)	183,334 (14.7)	282,003 (2.5)
Missing deprivation†	489 (3.4)	27,313 (2.4)	49,823 (1.9)

♠ The number of practices contributing data varies as each year a few practices leave the Vision system and a few join.

* Age at entry to study.

† Quintiles based on Townsend score for first registered address for child.

Appendix 4.5: Characteristics of children registered in 2010

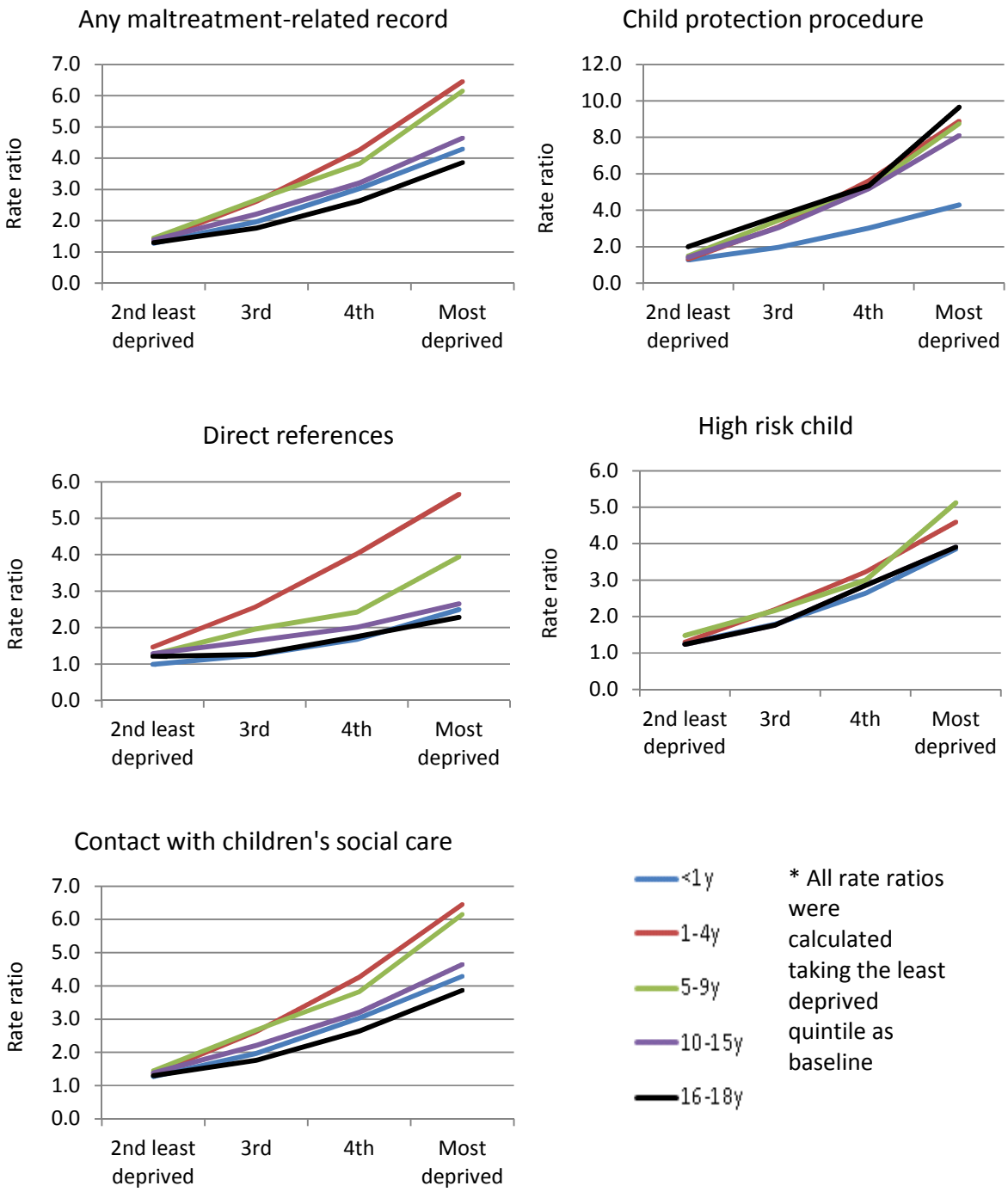
	2010 cohort 427 practices contributed data♠		
	Children ≥1 maltreatment-related code	**All children**	**Years at risk**
	N (%)		Sum (median)
All children	18907 (2.4)	769940 (97.6)	670,923.7 (1.0)
Boy	9, 565 (50.6)	393734 (51.1)	343,220 (1.0)
Girl	9, 342 (49.4)	376206 (48.9)	327,703.8 (1.0)
<1y*	9380 (49.6)	351389 (45.6)	312,640.4 (1.0)
1-4y*	4559 (24.1)	176842 (23.0)	158,517.7 (1.0)
5-9y*	3526 (18.6)	158188 (20.5)	137,386.4 (1.0)
10-15y*	1360 (7.2)	75185 (9.8)	58,494.5 (1.0)
16-17y*	82 (0.4)	8336 (1.1)	3,884.8 (0.5)
Least deprived quintile†	2122 (11.2)	188676 (24.5)	167471.4 (1.0)
2†	2074 (11.0)	152759 (19.8)	134429.8 (1.0)
3†	3627 (19.2)	153620 (20.0)	133679.9 (1.0)
4†	5106 (27.0)	144042 (18.7)	123938.4 (1.0)
Most deprived quintile†	5458 (28.9)	107683 (14.0)	92575.2 (1.0)
Missing deprivation†	520 (2.8)	23160 (3.0)	18829.1 (1.0)

♠ The number of practices contributing data varies as each year a few practices leave the Vision system and a few join.

* Age at entry to study.

† Quintiles based on Townsend score for first registered address for child.

Appendix 4.6: Relative rate of increase in maltreatment-related codes from 1995-2010, by age group and deprivation quintile and sub-category of code



Appendix 4.7: Prevalence (%) of children registered in 2010 with a maltreatment-related code, by category of code and child characteristic

	Percentage of children (95%CI)				
769940 children contributed data in 2010 (see Appendix 4.5 above)	Children with any maltreatment-related code N=6276	Children with a child protection procedure code N=2846	Children with a direct references* code N=1163	Children with a "high risk child" code N=2181	Children with a children's social care code N=879
All children	0.81 (0.80, 0.84)	0.37 (0.36, 0.38)	0.15 (0.14, 0.16)	0.28 (0.27, 0.30)	0.11 (0.11, 0.12)
Boys	0.79 (0.76, 0.82)	0.37 (0.35, 0.39)	0.15 (0.14, 0.17)	0.26 (0.25, 0.28)	0.11 (0.10, 0.12)
Girls	0.84 (0.82, 0.87)	0.37 (0.35, 0.39)	0.15 (0.14, 0.16)	0.30 (0.29, 0.32)	0.12 (0.11, 0.12)
<1y♠	1.47 (1.38, 1.57)	0.64 (0.58, 0.71)	0.28 (0.24, 0.32)	0.57 (0.51, 0.04)	0.15 (0.12, 0.18)
1-4y	1.15 (1.10, 1.21)	0.53 (0.50, 0.57)	0.22 (0.20, 0.25)	0.43, (0.40, 0.46)	0.13 (0.11, 0.15)
5-9y	0.76 (0.73, 0.80)	0.39 (0.36, 0.42)	0.12 (0.11, 0.14)	0.24 (0.22, 0.27)	0.11 (0.10, 0.13)
10-15y	0.72 (0.69, 0.76)	0.33 (0.31, 0.36)	0.14 (0.11, 0.14)	0.21 (0.20, 0.23)	0.13 (0.12, 0.15)
16-17y	0.31 (0.28, 0.34)	0.07 (0.05, 0.08)	0.07 (0.05, 0.08)	0.14 (0.12, 0.16)	0.06 (0.05, 0.08)
Least deprived†	0.35 (0.32, 0.38)	0.06 (0.05, 0.07)	0.07 (0.06, 0.09)	0.15 (0.13, 0.17)	0.06 (0.05, 0.07)
2	0.40 (0.37, 0.43)	0.05 (0.04, 0.07)	0.09 (0.08, 0.11)	0.14 (0.13, 0.17)	0.05 (0.04, 0.07)
3	0.78 (0.73, 0.83)	0.11 (0.10, 0.13)	0.10 (0.14, 0.18)	0.26 (0.24, 0.29)	0.11 (0.10, 0.13)
4	1.18 (1.13, 1.24)	0.15 (0.14, 0.18)	0.20 (0.18, 0.22)	0.40 (0.37, 0.43)	0.15 (0.14, 0.18)
Most deprived	1.75 (1.68, 1.82)	0.23 (0.21, 0.26)	0.28 (0.25, 0.32)	0.59 (0.54, 0.64)	0.23 (0.21, 0.26)
Missing	0.96 (0.84, 1.10)	0.18 (0.13, 0.24)	0.23 (0.18, 0.30)	0.29 (0.23, 0.37)	0.18 (0.13, 0,24)

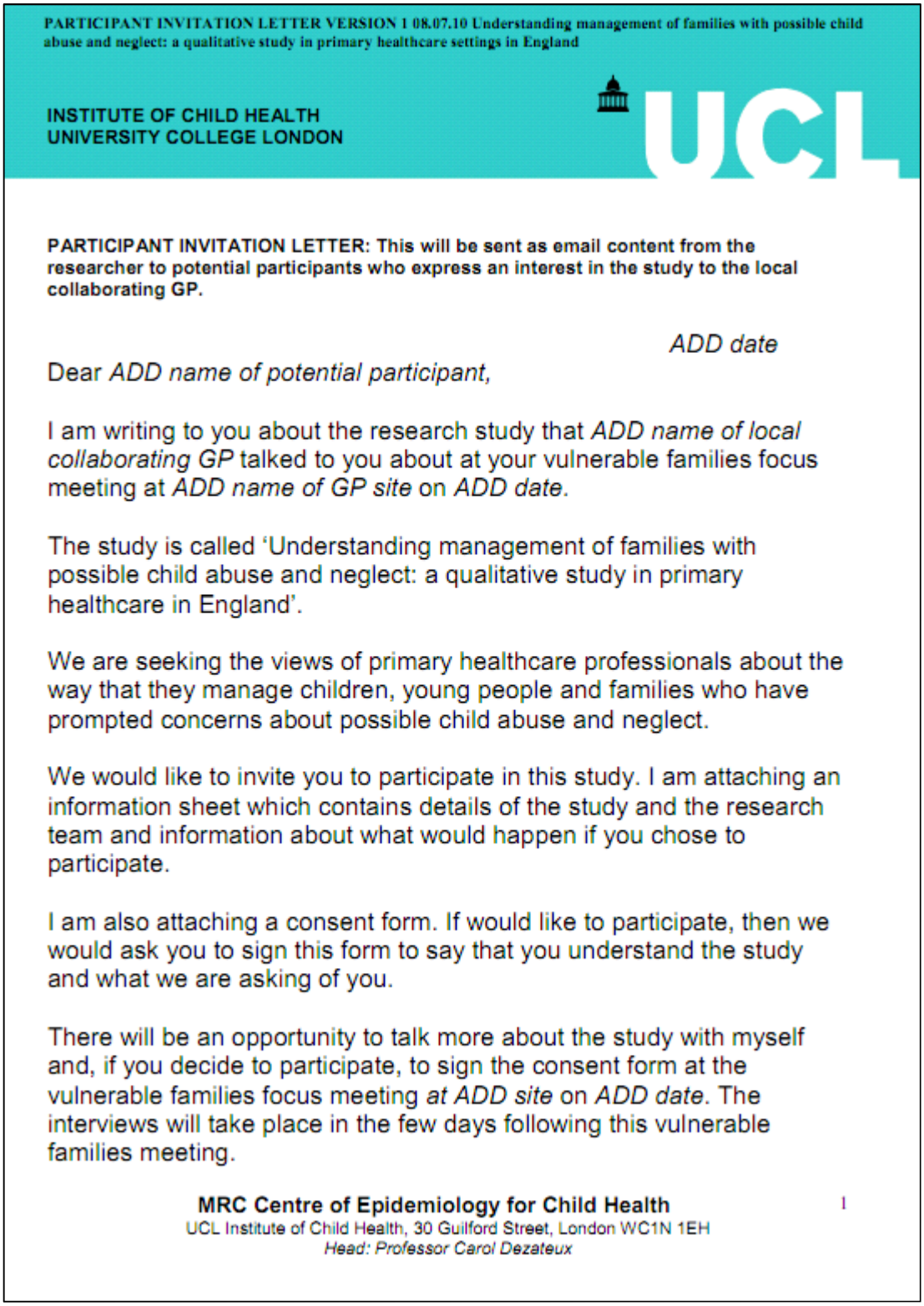
*to maltreatment/out-of-home care; ♠ Age at first MR code in 2010; † Deprivation quintiles based on Townsend score at first registered home..

Appendix 4.8: Sensitivity analyses

Incidence rates per 1000 child years in 2010 (95% CI)						
		Any maltreatment-related code	Child protection procedure	Direct reference to maltreatment or out-of-home-care	High risk child	Contact with Children's Social Care
Main analyses (reported in Chapter 4)	All ages	9.5 (9.3, 9.8)	4.3 (4.1, 4.4)	1.7 (1.6, 1.8)	3.3 (3.1, 3.4)	1.3 (1.2, 1.4)
	<1y	24.9 (23.3, 26.6)	10.8 (9.8, 11.9)	4.7 (4.0, 5.4)	9.6 (8.6, 10.6)	2.4 (2.0, 3.0)
Including temporarily registered patients.	All ages	9.6 (9.4, 9.8)	4.3 (4.1, 4.4)	1.7 (1.6, 1.8)	3.3 (3.1, 3.4)	1.3 (1.2, 1.4)
Excluding 5 months of time at risk following registration for all children, including infants.	All ages	8.9 (8.7, 9.1)	4.0 (3.9, 4.2)	1.6 (1.5, 1.7)	3.0 (2.9, 3.1)	1.3 (1.2, 1.4)
	<1y	18.1 (16.3, 20.2)	8.6 (7.3, 10.1)	2.9 (2.1, 3.7)	6.6 (5.5, 7.8)	1.8 (1.3, 2.6)
Including all time at risk after registration for all children.	All ages	10.6 (10.4, 10.8)	4.7 (4.5, 4.8)	2.1 (2.0, 2.2)	3.6 (3.4, 3.7)	1.4 (1.3, 1.5)
Analyses limited to 336 **English** practices.	All ages	9.9 (9.7, 10.2)	4.6 (4.4, 4.8)	1.8 (1.7, 2.0)	3.6 (3.4, 3.8)	1.1 (1.0, 1.2)

APPENDIX 5: Supplementary material for Chapter 5

Appendix 5.1: Copy of information sheet for participants



PARTICIPANT INVITATION LETTER VERSION 1 08.07.10 Understanding management of families with possible child abuse and neglect: a qualitative study in primary healthcare settings in England

INSTITUTE OF CHILD HEALTH
UNIVERSITY COLLEGE LONDON

UCL

PARTICIPANT INVITATION LETTER: This will be sent as email content from the researcher to potential participants who express an interest in the study to the local collaborating GP.

ADD date

Dear *ADD name of potential participant,*

I am writing to you about the research study that *ADD name of local collaborating GP* talked to you about at your vulnerable families focus meeting at *ADD name of GP site* on *ADD date*.

The study is called 'Understanding management of families with possible child abuse and neglect: a qualitative study in primary healthcare in England'.

We are seeking the views of primary healthcare professionals about the way that they manage children, young people and families who have prompted concerns about possible child abuse and neglect.

We would like to invite you to participate in this study. I am attaching an information sheet which contains details of the study and the research team and information about what would happen if you chose to participate.

I am also attaching a consent form. If would like to participate, then we would ask you to sign this form to say that you understand the study and what we are asking of you.

There will be an opportunity to talk more about the study with myself and, if you decide to participate, to sign the consent form at the vulnerable families focus meeting *at ADD site* on *ADD date*. The interviews will take place in the few days following this vulnerable families meeting.

MRC Centre of Epidemiology for Child Health 1
UCL Institute of Child Health, 30 Guilford Street, London WC1N 1EH
Head: Professor Carol Dezateux

Appendix 5.1 *Continued*: Copy of information sheet for participants

In addition, myself and the chief investigator for the study, Professor Ruth Gilbert, are also available for questions or discussion by phone or email (r.gilbert@ich.ucl.ac.uk 0207 905 2101 and j.woodman@ich.ucl.ac.uk 0207 905 2764).

After reading the attached material, please let me know if you anticipate attending the vulnerable families meeting on the *ADD date at ADD date* and might be interested in participating in the study. If you reply to the email, I will contact you to confirm availability for interview and discuss any queries.

If you do not reply to this email, there will be a further opportunity to arrange an interview at the vulnerable families focus meeting *on ADD date*.

If you do not want to participate, please let me know and you will not be approached again in relation to the study.

With best wishes

Jenny Woodman
PhD Research student
MRC Centre of Epidemiology for Child Health
UCL-Institute of Child Health
30 Guilford Street
London WC1N 1EH
Tel: 0207 905 2764

Appendix 5.2: Copy of interview schedule

INSTITUTE OF CHILD HEALTH
UNIVERSITY COLLEGE LONDON

UCL

INTERVIEW SCHEDULE

Understanding management of families with possible child abuse and neglect: a qualitative study in primary healthcare settings in England

The interview schedule will be used by the researcher to prompt participants during discussion of specific children, young people and families. Participants will be asked to four children, young people or families for discussion, although we anticipate that in most interviews only 1 or 2 children will be discussed in order to give adequate depth. The topics prompts below will be used for each child, young person or family who will be discussed one at a time, in turn.

SECTION 1: Introduction for participant (approx 5 minutes)

- Remind participant that the interview will be recorded and confirm consent (check recorder working)
- Record name of participant and interviewer and date, time and place of interview verbally (for recorder)
- Clarify aims of research
  - Understand the situations that prompt concerns about child maltreatment
  - Describe and understand the difficult decisions that you make in this context
  - Find out what primary healthcare professionals think they can do to help these families and why
- Clarify structure of the interview:
  - I will be asking you to tell me about specific children/young people/families from your practice.
  - I have asked you to choose four but it is very possible that we might only discuss 1 or 2. The interview is flexible in this way and allows you to say as little or as much as you choose about each child/young person/family.
  - Please can you refer to the children, young people or families as A, B, C and D and avoid using any identifying details about them.
- Advise participant of length of interview (up to an hour)
- Advise participant that there will be an opportunity to approve transcript (in about a week) and to give feedback on preliminary results from all sites (in about 6 months time)
- Explain that the interview can be stopped at any time and consent can be withdrawn at any time without reason and without implications and that data will be kept confidential (full quotes but anonymised)
- Ask if the participant would like to ask me anything about the research or the interview before we start

Appendix 5.2 *Continued*: Copy of interview schedule

SECTION 2: TOPIC GUIDES AND PROMPTS

1. Nature of concerns about child/young person//family

Example opening questions:

- I asked you to think of four children/families about whom you have been concerned. Can you start off by choosing one and tell me a bit about them and your concerns?

Possible prompts

- Why did you choose this particular child/family to discuss with me today?
- Can you tell me a bit (more) about the first time you were worried about this child/family?
- Can you tell me if there was anything else about the family that caused you think like that/helped you?
- How well do you know this family?
- How long has the mother been registered? Is the father registered with the practice?
- How has the situation for the child/family changed over this time? How would you describe these changes?

2. Recording of concerns and professional role

Example question: Can you describe how you worked with your colleagues/other professionals?

Possible prompts

- Did you share your concerns (How? With whom? What was the thinking behind sharing?)
- Were concerns recorded at any point? How were the concerns recorded?
- Can you explain the thinking behind your approach to this way of recording concerns/not recording concerns?

3. Decisions, actions, mechanisms and outcomes

Example question: I would like to know what happened next with this child/family.

Appendix 5.2 *Continued*: Copy of interview schedule

Example question: What did you decide to do about this child/family?

Possible prompts:

- Why do you think this happened?
- Did it make any difference?
- Have you or any of your colleagues seen someone from the family since then?
- How has your thinking developed?
- What was the result of the referrals or your action?
- Are you satisfied with this result?
- How will you follow this up?
- Would you do the same again?
- Did you consider doing anything else?
- Was there any point at which you were not sure what to do next?
- What was the most challenging aspect of managing this child/young person/family?
- What do you see happening to this child/family in the next few months/year?

4. How can primary healthcare services impact on child and family outcomes

Example question: how do you think you/ the primary healthcare team helped this child?

Example question: What would you like to see happening for this child/family in the future? How could the primary healthcare team help the child/young person/family towards this?

Possible prompts:

- Did/ could the primary healthcare team have a different role to other agencies for this child, young person/family?
- What was it about your primary healthcare team that made / would make you able to help this child/young person/family?
- Do you think all primary healthcare teams could have helped in the same way that you / yours did?

Appendix 5.2 *Continued*: Copy of interview schedule

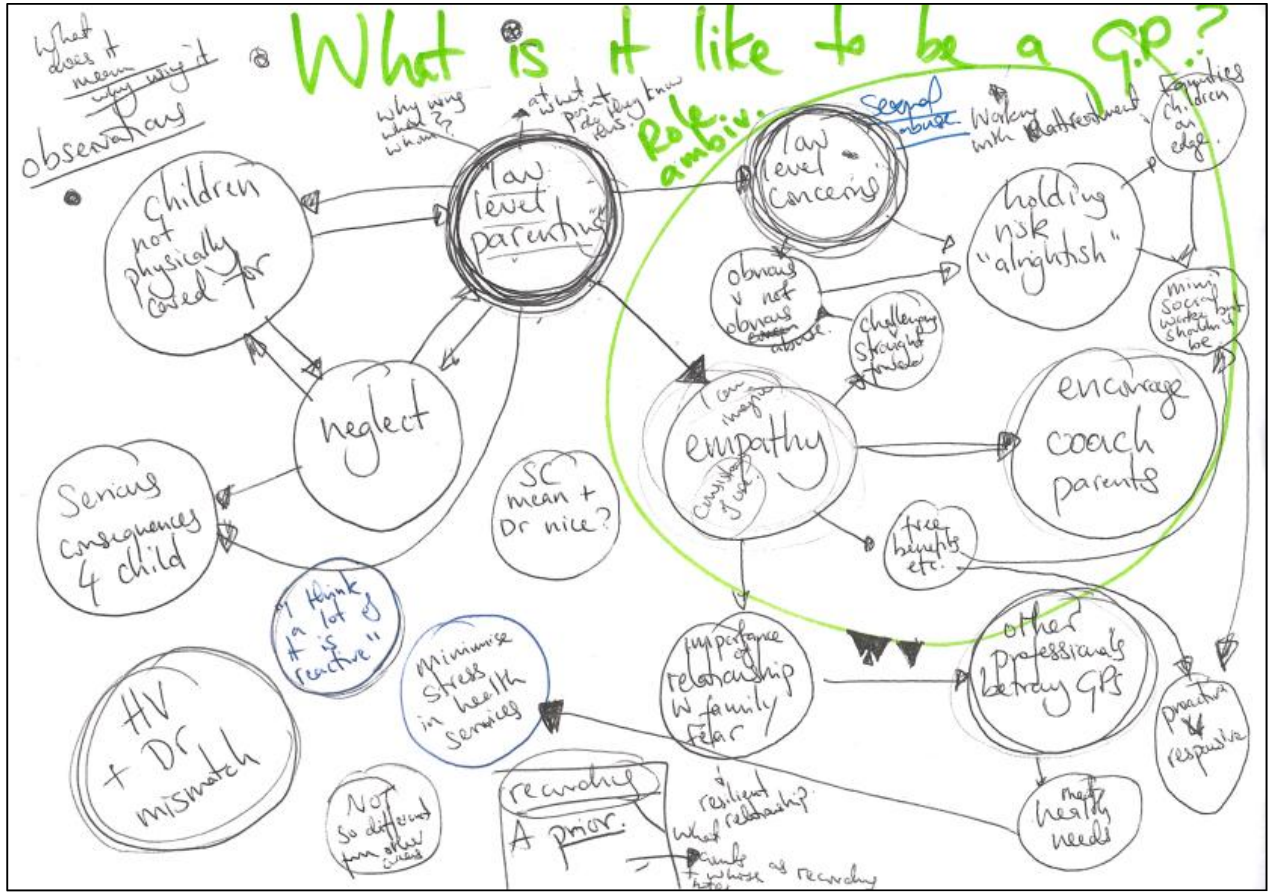
5. Opportunity for other comment

Example question: Would you like to tell me anything else about this child/young person or family?

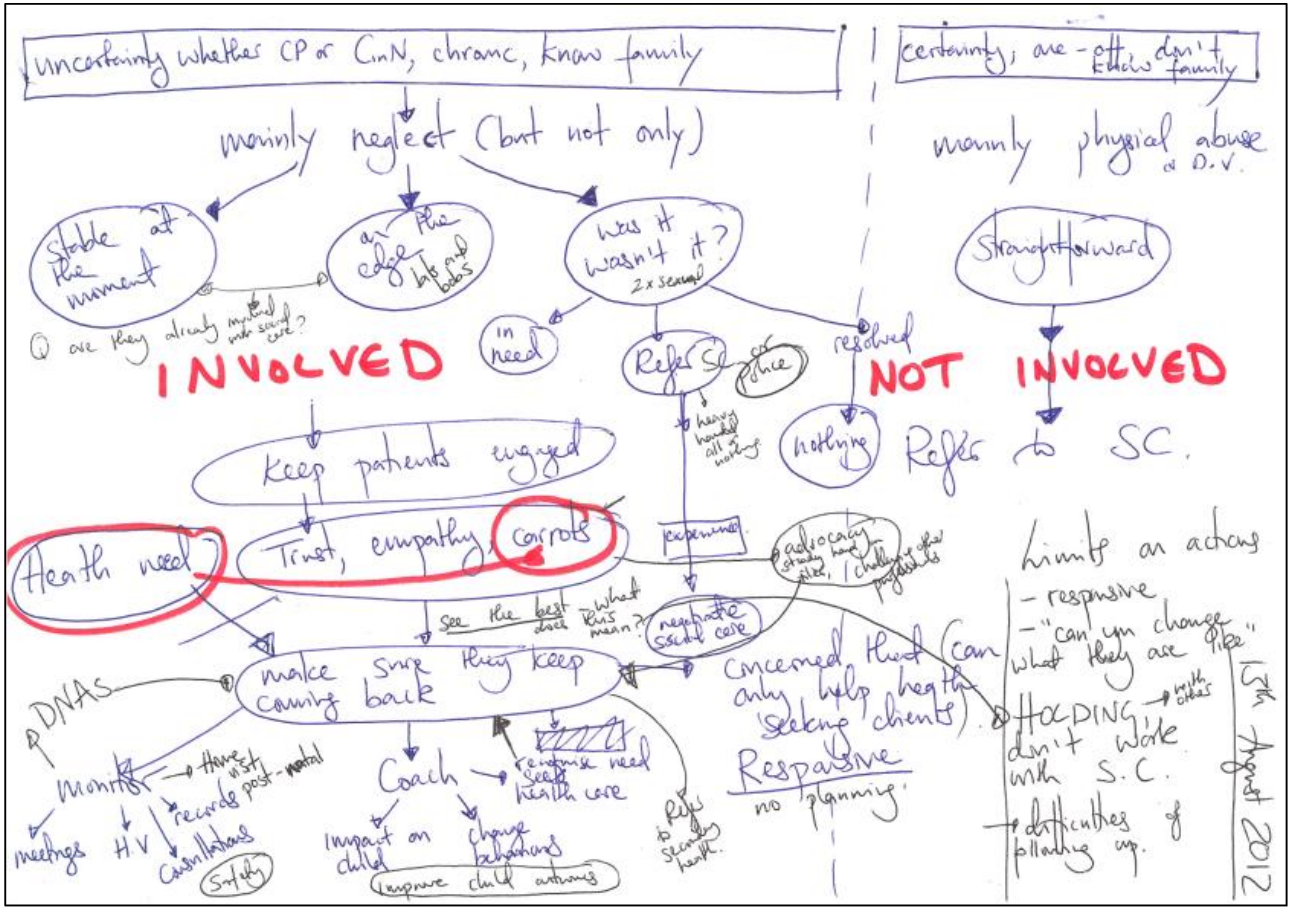
Example question: Is there any thing else you would like to discuss or tell me?

Once child/young person/family A has been discussed, the interviewer will start from the beginning of the topic guide for child B and repeat either until the interview concludes (maximum 1 hour) or when four children have been discussed.

Appendix 5.3: Mind map (part of qualitative analysis): October 2011



Appendix 5.4: Mind map (part of qualitative analysis): August 2012



Appendix 5.5: A4 folded leaflet used to feedback results to GPs.

Study methods

- Interviews with GPs (N=13) health visitors (N=2) and practice nurses (N=2) from four General Practices in England.
- This study focuses on GPs. Data from health visitors and practice nurses was used to support and contextualise findings.

Why do I want your feedback?

- I would like to understand whether my interpretation of the data resonates with participants. I have some specific questions for participants (see opposite).
- Feedback also allows participants to see the end result of their interview and is a way of acknowledging my gratitude for participation.

How can you give feedback?

- Email me: j.woodman@ucl.ac.uk
- Call me: 0207 905 2764
- Write to me: J Woodman, MRC Centre for Epidemiology of Child Health, UCL-ICH, 30 Guilford Street , London WC1N 1EH

QUESTIONS FOR GPs

1. How far do you recognise the four types of families? Do they reflect your child safeguarding workload?
2. Do the four responses reflect what you do for families with maltreatment concerns (in addition to referring to and working with social care)?
3. Do you consider the four responses part of 'normal' GP practice (i.e. are these strategies you routinely use for other patients)? If so, which patients?
4. When used in response to maltreatment concerns, would you see the four responses as :
    - 'safeguarding' work?
    - 'child protection' work?
    - something else?
5. Do you have any other feedback?

How will the feedback be used?

Feedback will be anonymised and confidential. It will contribute to the final results and guide interpretation.

This study formed part of my (Jenny Woodman's) PhD, which was funded by the Economic and Social Research Council and the Medical Research Council.

Concerns about child abuse or neglect:

What are GPs doing, for whom and how?

Provisional study results: opportunity for participant feedback

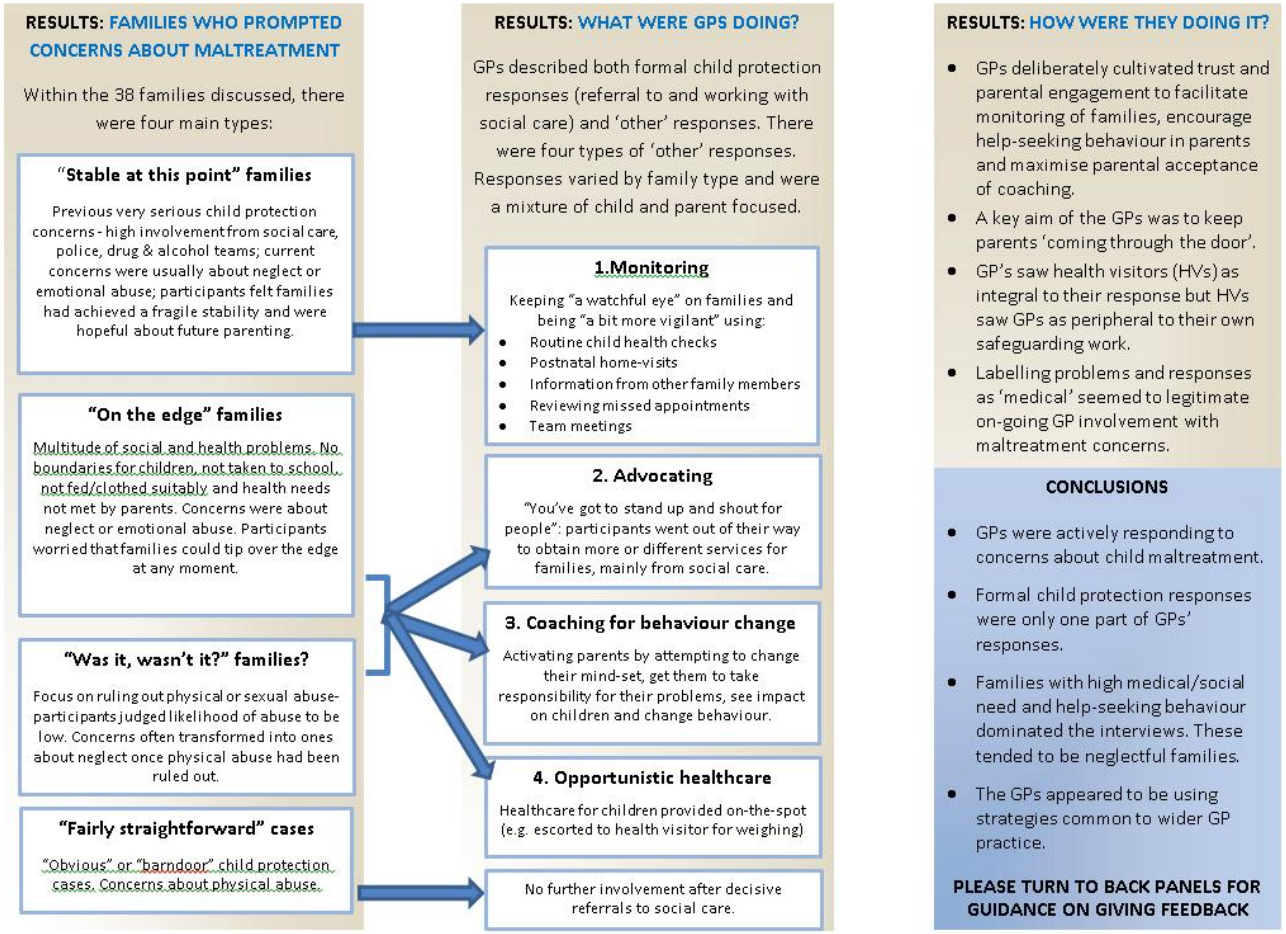
Study results are displayed on the inside of this leaflet. Guidance for feedback is on the two back panels.

DEADLINE FOR FEEDBACK: MONDAY 17th DEC 2012

November 2012

Picture taken from http://images.google.co.uk/

Appendix 5.5 *Continued*: A4 folded leaflet used to feedback results to GPs.



Appendix 5.6: Methods for literature review on GP-patient relationship from parental and young person perspectives

Inclusion criteria

I sought any kind of study, report or document (including webpages) that reported parent, young person, adolescent or child views and/or experiences of the doctor-patient relationship in general practice or GPs in any of the four UK countries. I used the following inclusion criteria:

- Data must have been collected in 2004 or later (i.e. following implementation of new 2004 GP contract - also coincides with the introduction of a 'qualitative' MeSH term in MEDLINE in 2003).
- Must be a research study, audit, service evaluation or local intervention which included an evaluative element.
- Must report the views of parents and/or young people and/or children about the doctor-patient relationship in UK general practice. Adult patients must be asked in their capacity of parents (i.e. not just participants who might also have children). The doctor-patient relationship was interpreted broadly to include relevant themes such as continuity of care, perceived empathy or listening skills or perceived role of the doctor in responding to social problems.
- Can include general population or be restricted to vulnerable or socially disadvantaged groups (but we will not include studies focussed on specific conditions such as asthma or cancer).
    - Views can be about:
    - standard care in general practice.
    - interventions or service modifications which were designed to improve delivery of services to parents, and/or young people and/or children.

- specific GPs or specific consultations or a specific practice or group of practices.

- Views can be measured via surveys (quantitative data) or through in-depth interviews/focus groups (qualitative data).

Searches

Due to poor indexing and the writing conventions of qualitative research, much relevant research reporting patient views and experiences will be missed if researchers limit their search sources to large health databases.[5 6] For this reason and because I wanted to include grey (unpublished) literature, I used a range of search strategies (see Table A5.7 below).

Table A5.1: Search sources and methods

Search # and source	Dates searched	Methods/ terms
#1 MEDLINE (via Ovid)	04.02.14	(Qualitative research or survey) and (general practice or GP) and UK and (parents or young people or adolescent or children) See Table A2 below for full details
#2 Google and Google Scholar	05.02.14	Used the following terms and looked through the first hundred hits on both search engines: GP and relationship and (children or adolescent and parent and young people) and UK AND published in/after 2004
#3 Key informant	Jan-Feb 2014	Emailed contacts (N=7) at the RCGP and other experts e.g. deep end GPs http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/
#4 Websites	Feb 2014	Association for young people's health http://www.youngpeopleshealth.org.uk/5/our-work/71/gp-champions-project/ General Practitioners at the deep end http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/ National Children's Bureau http://www.ncb.org.uk/ Royal College of GPs http://www.rcgp.org.uk/
#5 Biblio-graphies	Feb 2014	Searched the bibliographies of included studies and 7 included literature reviews (see Appendix 6.13, Table A6.2 for details of reviews). For journal publications, I used the "related citation" search in PubMed. I contacted authors where appropriate. • Hagell 2013[7] • Clements 2013[8] • Hargreaves, 2012[9] • La Valle 2012[10] • Lavis 2010[11] • Robinson 2010[12] • Freake 2007[13]

Table A5.2: Full MEDLINE search strategy

RUN ON 04.02.14			
Concept		Terms*	Hits
Setting	#1 General practice	(primary adj care).ab,ti. OR GP*.ab,ti. OR (general adj practi*).ab,ti. OR (general practice).sh. OR (general practitioners).sh.	242701
	#2 UK	(United Kingdom).ab,ti. OR UK.ab,ti. OR England.ab,ti.OR England.sh. OR Wales.ab,ti. OR Wales.sh. OR (Northern Ireland).ab,ti. OR (Northern Ireland).sh. OR Scotland.ab,ti. OR Scotland.sh.	210950
Population	#3 Parents, YP, adolescents or children	parent*.ti,ab. OR parent.sh. OR family*.ti,ab. OR families.ti,ab. OR family.sh OR mother*.ti,ab OR mothers.sh. OR father*.ti,ab. OR father.sh. OR (young adj person).ti,ab. OR adolescent.ti,ab. OR adolescent.sh. OR adolescent health services.sh.OR teenage*.ti,ab. OR child*.ti,ab. OR child.sh. OR child health services.sh.	3443359
Study type	#4 Qualitative research**	interview.mp. OR experience.mp. OR qualitative.tw.	660460
	#5 Patient surveys/ questionnaire	questionnaire*.ti,ab. OR questionnaires.sh. OR survey.ti,ab.	708530
	#6 Audit	Audit.ti,ab.	22953
	#7 Evaluation	evaluation studies.sh. OR evaulat*.ti,ab.	207131
Topic	#8 doctor-patient relationship	(physician patient relations or physician's role or "patient acceptance of health care").sh. OR (engagement OR relationship OR trust OR continuity).ti,ab.	815237
Date	#9 2004 onwards		
	#1 AND #2 AND #3 AND (#4 OR #5 O #6 OR #7) AND 8 AND #9		294

*ab=abstract; ti=title; sh=subject heading (i.e. indexed term); mp= multi-purpose (title, original title, abstract, subject heading, name of substance, and registry word fields)
** Filter developed by team at McMasters for optimal sensitivity and specificity for qualitative research about human health in MEDLINE database (via Ovid)
http://hiru.mcmaster.ca/hiru/HIRU_Hedges_MEDLINE_Strategies.aspx#Qualitative

Appendix 5.7 Letter of Approval from NHS Research Ethics Committee

NHS

National Research Ethics Service

Central London REC 1
Level 7N019, Maternity Block
Northwick Park Hospital
Watford Road
Harrow
Middx
HA1 3UJ

Telephone: 020 8869 3775
Facsimile: 020 8869 5222

08 October 2010

Professor Ruth Gilbert
Professor of Clinical Epidemiology
University College London-Institute of Child Health
30 Guilford Street
London
WC1N 1EH

Dear Professor Gilbert

Study Title:	**Understanding management of families with possible child abuse and neglect: a qualitative study in primary healthcare settings in England**
REC reference number:	**10/H0718/61**
Protocol number:	**N/A**

Thank you for your letter of 14 September 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC at a meeting held on date 01 October 2010. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the

Appendix 5.7 *Continued*: Letter of Approval from NHS Research Ethics Committee

study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Investigator CV		08 July 2010
Protocol	2	11 September 2010
Student CV Jenny Woodman		08 July 2010
Evidence of Findings		14 April 2008
REC application		07 July 2010
Letter of invitation to participant	1	07 July 2010
Participant Information Sheet	2	14 September 2010
Response to Request for Further Information		14 September 2010
Participant Consent Form	2	11 September 2010
Second Supervisors CV Marian Brandon		07 July 2010
Tertiary Supervisor CV Danya Glaser		07 July 2010
Evidence of insurance or indemnity	7	02 July 2010
Referees or other scientific critique report	1	07 July 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

Appendix 5.7 *Continued*: Letter of Approval from NHS Research Ethics Committee

10/H0718/61 **Please quote this number on all correspondence**

Yours sincerely

PP Julie Kidd.

Dr John Keen
Chair

Email: Julie.kidd@nwlh.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written*
"After ethical review – guidance for researchers"

Copy to: *Tracy Assari*
UCL Institute of Child Health
30 Guildford Street
London
WC1N 1EH

Appendix 5.8 Anonymised "Letter of Access" from one PCT

NHS

Date: 23 November 2010

Jenny Woodman
MRC Centre for Epidemiology of Child Health,
UCL-institute of Child Health,
30 Guilford Street,
London,
WC1N 1EH

Dear Jenny

Letter of access for Primary healthcare management of possible child abuse and neglect - 10PC003

This letter confirms your right of access to conduct research through PCT for the purpose and on the terms and conditions set out below. This letter allows access within . This right of access commences on 22/11/10 and ends on 28/09/2012 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. **Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.**

The information supplied about your role in research at has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through , you will remain accountable to your employer University College London but you are required to follow the reasonable instructions of **[head of relevant NHS Department/research supervisor]** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with PCT policies and procedures, which are available to you upon request, and the Research Governance Framework.

Appendix 5.8 Continued: Anonymised "Letter of Access" from one PCT

You are required to co-operate with PCT in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on PCT premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Where required by law, your HEI employer will initiate your Independent Safeguarding Authority (ISA) registration, and thereafter, will continue to monitor your ISA registration status via the on-line ISA service. Should you cease to be ISA-registered, this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity. You MUST stop undertaking any regulated activity.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

PCT will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

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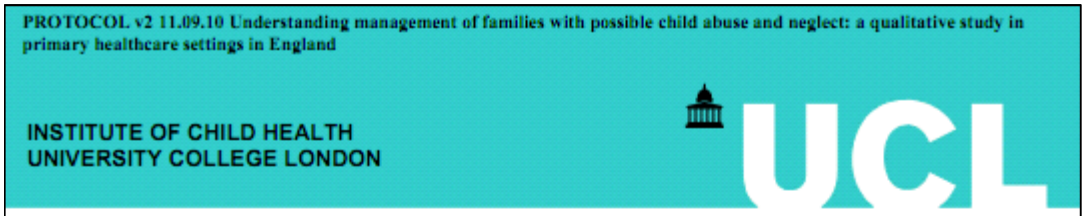
The protocol was followed in the study with the exception of timing. It was not practical to interview the participants within such a short time-frame and analysis took much longer than expected so feedback was both delayed and curtailed. I wrote to participants to inform them of the delays and update them of the study progress.

Appendix 5.9 *Continued*: Protocol for study (sent to NHS Research Ethics Committee), with ethical procedures highlighted in yellow



INSTITUTE OF CHILD HEALTH
UNIVERSITY COLLEGE LONDON

Study title: Understanding current management of children who prompt concerns about maltreatment and identifying future directions: a qualitative study in primary healthcare settings in England

Funding: Medical Research Council and Economic and Social Research Council 1+3 Interdisciplinary Studentship

Dates: September 2009 to September 2012

Research Team:

- Jenny Woodman, UCL-Institute of Child Health: Researcher
- Professor Ruth Gilbert, Professor of Clinical Epidemiology, UCL-Institute of Child Health, London: Chief investigator and principal supervisor for study
- Dr Marian Brandon, Senior Lecturer in Social Work (Children and Families), University of East Anglia, Norwich: secondary supervisor
- Dr Danya Glaser, Consultant Child and Adolescent Psychiatrist, Great Ormond Street Hospital, London: tertiary supervisor
- Dr Imran Rafi, Medical Director RCGP-Clinical Innovation and Research Centre and GP principal: collaborator
- Dr Janice Allister, RCGP Safeguarding Lead and GP locum: collaborator

Contact: Jenny Woodman email: j.woodman@ich.ucl.ac.uk tel: 0207 9052764

This study will contribute towards a PhD award for Jenny Woodman.

BACKGROUND

Why should we focus on services for maltreated children?

Child maltreatment (child neglect or emotional, physical or sexual abuse) affects about 1 in 10 children and young people each year in the UK.[1] Maltreated children and young people are at risk of the immediate and life-long consequences of maltreatment which include injury, mental health and behavioural problems, risky sexual behaviour and criminality.[1] In addition to population-health arguments, there are strong human rights arguments for intervening to improve the well-being of children who are maltreated or highly vulnerable to maltreatment.[2] A broad range of programmes for child maltreatment exist and the evidence base, though limited, suggests that child and family well-being can be improved through social welfareinterventions.[3]

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Why should we focus on primary healthcare management of maltreated and at risk children, young people and families?

This study focuses on the role that primary healthcare services can play in recognising and supporting maltreated and highly vulnerable children, young people and their families in order to prevent or reduce maltreatment and to improve the well-being of the child and their family. Primary healthcare services are a universal service (first point of contact with patients), offer family-centred care and often have contact with multiple family members over many years. Primary health care professionals deliver team-facilitated care, can act as a repository for patient information and are responsible for on-going care of the child or young person and their family. As a result, primary healthcare services are well placed to recognise children and young people at risk of child maltreatment and offer or facilitate access to early and therapeutic interventions for these children, young people and their families.

Widespread recognition of the importance of universal services, such as primary healthcare, is reflected in policy shift towards promoting the role of universal services in child protection work. In line with this, the independent review of child protection systems in England, lead by Eileen Munro, was specifically asked to focus on improving the contribution of universal services.[4]

Therapeutic and supportive interventions by primary healthcare professionals for the child or young person might include: referral to Children's Social Care, to CAHMS (Child and Adolescent Mental Health Services), to physiotherapy or occupational therapy, to the school nurse or school or college counselling services, to a sexual health clinic, to a specialist drug and alcohol services, or to housing services. For the parents, actions might include: referral to SureStart, to housing, to debt advice services, to adult mental health services, to community health services or voluntary sector services for domestic violence or drugs and alcohol. It might also include facilitating access to a nursery place; triggering Health Visitor visits; offering in-house counselling or fostering a therapeutic relationship between the family and practitioner. Often the Health Visitor will be working very closely with families with young children. All these involve various degrees of information sharing with other agencies. In addition, primary healthcare professionals might monitor the family, assess risk and need at regular intervals and/or hold team meetings to discuss management of the families.

These systems for supporting children and families who give rise to concerns about possible child maltreatment in primary care settings use universal services but, together, are expensive and use resources that could be employed elsewhere. If such intensive support involves labelling, there is potential harm (such as discouraging use of services) by stigmatising and intrusive surveillance.[5]. For these reasons it is important that we understand what constitutes 'best practice' for responding to concerns about child maltreatment in the primary healthcare system Practice should be effective, efficient and do more good than harm.

Recognition of possible child maltreatment is difficult and decisions about how to support the children, young people and families is fraught with uncertainty. The family situation is often complex with family members having chronic health and social welfare needs.

What do we already know about the effectiveness of primary healthcare management of children, young people and their families who prompt concerns about maltreatment?

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Most relevant research has evaluated home-visiting programmes (such as those that could be delivered by Health Visitors). Intensive home-visiting programmes have been shown to be effective in reducing child maltreatment among disadvantaged sub-groups of parents.[3] Most evidence is from the USA and New Zealand and should be extrapolated to the UK context with caution. Currently a Randomised Controlled Trial of intensive home-visiting is being conducting in the UK (results not yet available).

Evaluations of home-visiting programmes do not take into account the support and expertise that the rest of the primary care team could provide.

Preliminary background searches for this study identified one other relevant evaluation of a intervention for maltreated children in a primary healthcare setting, the results of which suggests that training and organisational modifications in primary care might constitute a promising intervention for child maltreatment. In this American study, the children in the primary healthcare care intervention sites (which had extra professional training, an identification tool for maltreatment and a resident social worker) were found to have a lower risk of maltreatment compared to children who had received standard care.[6] Due to extensive differences between the UK and American healthcare systems, the results of this study should be viewed cautiously in a UK context.

How can we improve our knowledge-base about management of children, young people and families who prompt concerns about child maltreatment in primary healthcare settings?

A service-based intervention (organisational and structural rather than programmatic) such as that offered by the primary care team is complex and consists of multiple components which act independently and inter-dependently. This poses specific challenges for the evaluation of the way that maltreated and at risk children and young people (and their families) are managed. Factors that aid the robust development of complicated management pathways and models of best practice in areas such as these include drawing on multiple data sources, including qualitative data and allowing sufficient time and resources for the describing management and developing theory about what might work and how.

Aim: This study uses qualitative methods to improve understanding of how primary care professionals manage children and families who give rise to concerns about possible child maltreatment. The study will generate ideas about which current or potential components of primary healthcare services might be 'active ingredients' in improving the well-being of these children and families and how these 'active ingredients' might work.

The results will be used to generate hypotheses about models of best practice for children and families who give rise to concerns about possible child maltreatment in primary healthcare settings.

Objectives:

1) To understand how members of the primary healthcare team view their role in managing children and families who give rise to concerns about possible child maltreatment.

2) To understand what prompts the primary healthcare team to be concerned about possible child maltreatment, how they describe and record these concerns.

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3) To describe and understand the decisions that that are taken by the primary healthcare team, especially for children and families who prompt concerns about possible child maltreatment and do not meet thresholds for a referral to/intervention by Children's Social Care

4) To elicit professional views about how primary healthcare services might impact upon the well-being of children and families who give rise to concerns about possible child maltreatment, including mechanisms by which the services are thought to work.

5) To generate ideas about which current or potential components of primary healthcare services might be 'active ingredients' in improving the well-being of children and families who prompt possible child maltreatment concerns.

Study design: The study will use a qualitative design. Semi-structured interviews will be conducted with a maximum of 16 primary care professionals from a maximum of five GP practices in England. The qualitative data will provide a description of complex pathways of care for maltreated and at risk children and their families and will generate hypotheses about how components of the intervention are likely to work to improve child and family outcomes. A clear understanding of the system and theory about how it is likely to work is essential for developing models of best practice that that have a credible chance of improving the well-being of maltreated and at risk children and their families.

Identifying data collection sites: In order to ensure we access data which will most effectively generate hypotheses about models of best practice, we aim to collect data from 'best practice' primary healthcare sites. These sites will be chosen from a convenience sample of GP practices with specialist interest and expertise in managing maltreated and vulnerable children and their families. Many of these sites are lead by professionals who contribute to policy and are opinion leaders in this field. The convenience sample consists of a group of 11 self-selected GP practices from across England, all of which are currently contributing data to a Royal College of General Practitioners Child Safeguarding audit (running for 3 years from April 2010). From the 11 potential sites in the sampling framework, we will collect data from up to five sites.

The sample of up to five data collection sites will be chosen according to the regularity of their team meetings to discuss vulnerable families. The occurrence of regular and well-attended team meetings to discuss vulnerable families is likely to be a marker of good Child Safeguarding practice and sites with the most regular and most well-attended of these meetings will be chosen for data collection sites. In addition sites will be chosen to reflect different practice size, deprivation level of surrounding area, geographical region and management structure.

The student researcher and her primary supervisor are providing scientific support for the Royal College of General Practitioner child safeguarding audit and have been working with the core group and the 11 participating GPs since January 2010. The research team presented this proposed qualitative study to the core group of the audit (lead by the Medical Director, RCGP-Clinical Innovation and Research Centre) who assessed that it usefully extended the work of the audit and agreed that the research team may contact the 11 participating sites briefly explaining the research and invite GPs to opt in or out.

Information about characteristics of the 11 practices was collected as part of the Child Safeguarding Audit in May 2010. This information includes details of the frequency and members of the 'vulnerable families' meetings.

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Appendix 5.9 *Continued*: Protocol for study (sent to NHS Research Ethics Committee), with ethical procedures highlighted in yellow

PROTOCOL v2 08.07.10 Understanding management of families with possible child abuse and neglect: a qualitative study in primary healthcare settings in England

Identifying potential interview participants: The interview participants will be sampled from the health practitioners that attend the meetings to discuss vulnerable families. At least one of these meetings at each site will be attended by the researcher. Potential participants include: GPs, Practice Nurses, Named Nurses for Child Protection, Health Visitors, Community Psychiatric Nurses and on-site Counsellors. Participants must have had personal experience of managing a child or family that gave rise to concerns about possible child maltreatment. Participants at each site will be chosen to give a range of professional roles. Where necessary (i.e. where there are multiple professionals in one role), the local collaborator GP (the GP leading the RCGP audit in each site) will help identify participants with specialist interest and/or expertise in child safeguarding.

Approaching potential participants: The local collaborating GP at each site will introduce the study to potential participants (the primary healthcare team) at a pre-selected vulnerable families meeting. This will happen at least two weeks before scheduled data collection. Where verbal permission is given by potential participants to the collaborating GP, the researcher will contact potential participants to ask about attendance at the next vulnerable families meeting and to send the information sheet and written consent form. The participants will have at least a week to decide whether or not they wish to participate in the study. The researcher and her principal supervisor will be available during this time (by phone or email) for questions and/or further details. Contact details will be on the Research Participant Information Sheet.

Seeking informed consent: Participants who agree to participate by email will be asked to give written informed consent at the following vulnerable families meeting, which will be attended by the researcher.

Interviews: Semi-structured, in-depth interviews will be conducted with a maximum of 16 participants. Each interview will last a maximum of an hour and will take place at the GP site within 3 days of the index vulnerable families meeting. Where necessary, the student researcher will stay overnight near the research site during the period of data collection.

During the interview, the researcher will ask professionals to talk about up to four children or young people (or families) that they have managed in order to elicit views about the role of primary healthcare in the management of maltreated children or young people and their families, current service provision for these groups and the mechanisms by which primary healthcare services might impact on the well-being of maltreated and at risk children, young people and their families.

Participants will be given guidance on how to choosing these children in the Research Information Sheet. Participants will be asked to choose four children, young people or families with whom they feel they were directly involved and whom they can remember well. No other criteria will be given. It will be made clear to participants that the research team is interested in learning which children are 'important' or 'concerning' to practitioners and this is why we have not given detailed criteria for choosing children for discussion. We are interested in all children and young people, regardless of age, type of abuse or neglect and whether or not they simultaneously or eventually received services from Children's Social Care Services.

In order to maximise the richness (and usefulness) of the data, the researcher will encourage in-depth discussion of one or two children or young people (or families) rather than brief discussion of all four in the interview. The participants have been asked to select four children or young people (or families) to ensure that the interview can continue if the participant does not, in fact, have in-depth knowledge of each child, young person or family.

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The participants will be asked to name the children A, B, C and D and, in the interview, not to name children, their family members or their schools, places of work, home addresses or date of birth. Participants will be reminded of this at the beginning of the interview. Within 3 working days of the interview, the collaborating GP at each site ask the participant for the names of the children that the participant discussed in the order in which they were discussed and enter this onto an excel spreadsheet (supplied by the researcher). This will allow the collaborating GP to see if any participants have discussed the same children. If there is any overlap between children discussed, the collaborating GP will give each child their own unique code on the excel spread sheet (e.g. Child 1, Child 2 etc) and will then generate a copy of the excel document without the child names (i.e. just the codes). This anonymised sheet will be sent to the researcher. If there is no overlap between the children discussed by participants in the practice, the collaborating GP will let the researcher know and no further action is needed. As the practices are geographically very far apart, we will assume that there will not be overlap of children discussed by participants from different practices.

Interviews will be digitally recorded and transcribed by the student. The transcription and analysis process will be started as soon as the data collection begins and will place alongside the remaining interviews. Participant names will not be recorded on the transcript. Instead a code will be used (e.g. Participant 1), the key to which will be kept as a separate and encrypted file stored on the secure server. The transcripts will be shown to the participants for approval and participants will be able to amend or delete any statements attributed to them in the transcripts (approx 20 minute of participants' time for reading transcript). The transcripts will be sent via encrypted email to the participants, with the encryption password given via telephone. Anonymised data will be stored as password protected encrypted files on a secure UCL server to which only Jenny Woodman and Ruth Gilbert have access.

Data analysis: The data will be analysed using robust thematic analysis; that is the contents of the interviews will be read several times to identify themes and categories. The data will be coded according to the relevant themes which emerge from the data. The emergent themes will be used to refine the data collection e.g. to either modify the interview topic guide or to identify participants to sample purposively. The themes/categories will be refined during the analytic process and associations between phenomena mapped. Selected coded transcripts will be reviewed by the researcher's supervisor, Dr Brandon (an expert in qualitative research) to ensure intellectual robustness. Emergent themes and categories will be discussed with the supervision team, the methodological working group and the core group of GPs (from the RCGP safeguarding audit).

Feedback to participants: There will be a 45 minute group feedback session for the primary care team at each site, in which preliminary findings from all data collection sites are discussed and participants have an opportunity to comment on analyses and interpretation. The feedback session is an opportunity for shared learning. It will constitute continued professional development training for the primary healthcare team and will take place in a training session allocated for this purpose. Participants unable to attend the feedback session will have opportunity to comment on a written summary by email. Anonymity of participants will be maintained during the feedback session.

Researcher/Observer bias:
Within the qualitative research paradigm there is an implicit understanding that a researcher's own background will invariably affect the research process. There is an emphasis in qualitative research methodology on reflexivity; that is personal characteristics and intellectual biases must be made explicit in the presentation of findings to allow readers to assess the interpretation and to give the research credibility.

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Timeline:
The primary data collection and participant involvement will take place in the second year of the researcher's PhD studentship (from October 2010 to October 2011). However, analyses and dissemination will continue until September 2012. The preparatory phases of the study, including researcher training and seeking feedback from healthcare professionals on the study design, have been taking place since September 2009.

Interviews in all the data collection sites will take place over approximately six months and the interview data will be simultaneously transcribed and analysed. Participants will be shown their transcript within 10 days of the interview and the feedback session on preliminary analyses will be given within six months of data collection in each site.

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Appendix 5.10: Letter (anonymised) for participant's revalidation portfolios

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13th May 2011

Dear Dr

Thank you very much for your participation in our study 'Understanding management of families with possible child abuse and neglect: a qualitative study in primary healthcare settings in England"

Involvement to date includes participating in an hour long interview about your experiences of managing children with maltreatment concerns.

The study is funded jointly by the Medical Research Council and the Economic and Social Research Council via an interdisciplinary studentship awarded to myself and is registered on the Comprehensive Research Network Portfolio
http://public.ukcrn.org.uk/Search/StudyDetail.aspx?StudyID=8683
(CSP ref: 54588; CRN ref 8683).

Your involvement has been extremely valuable.

Thank you for your time

Yours Sincerely

JENNY WOODMAN

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APPENDIX 6: Supplementary material for Chapter 6

Appendix 6.1: Full description of a "stable at this point in time" narrative

Uses participant's own words

"The concerns that we've had with this child throughout her life is really firstly her mum was a known drug user throughout her pregnancy […] Then when she was eight weeks old, it was reported to the police that there had been a domestic violence incident at the home, and the baby was in the home [and in danger]. And the first time I saw her bring her in on her own was when her skin was very, very infected. […] And I was alerted to the fact that really she had let her skin get in a very poor condition before she had done anything about it […] two to three weeks later she presented again in the same condition […] So, really, things progressed on throughout her short life, er young life, of really neglect, really within the home. Her mum wasn't using drugs anymore, but she was drinking and there was an increasing amount of violence occurring in the home. Eventually, we had an incident where […] not only had [the father seriously injured] the mum, but he had taken the two children hostage as well in the property [and the police had to intervene]. […] So, again, social services were very heavily involved with both children again, because they were at risk in the family home.

[…But now] Her mum is working, and we've had much -- although she's still a child of concern, we've had much less worry about her of late. Because, in actual fact, on this last altercation with her partner, [the father] did get a custodial sentence. So for the last sort of six months things have been going much better for this particular child, and her mum has been doing much better. And even though we are concerned, things have been going much better.

So I feel that her life has improved […] But she is obviously still a concern, because, you know, at any point her father who is going to be released could have contact with her again."

Participant 9, practice nurse, Family 23, 2 year old child a with older sibling

[…] signals omitted text and [ ] signals paraphrased text.

“stable at this point of time, but it's a never ending story”

The most common narrative was of families who had experienced extremely serious social problems but who had since achieved a fragile stability. These stories were characterised by a history of long-term parental drug and/or alcohol use, parental mental health problems and serious domestic violence. The participants described extensive contact with child protection services, police and drug and alcohol services for these families. Often participants knew about older siblings having been taken into care and, in one case, the previous death of a sibling due to co-sleeping.

Participants described how they felt that circumstances had improved for children in these families and how they had some hope for the parents’ capacity to look after their children. However, at the same time they also presented the new stability as fragile and the optimism about the future was cautious and uneasy.

> “I think we’ll probably always be a bit more vigilant and little bit more worried, particularly with any parent who has been that chaotic, who has had a bereavement, who has… I think yeah, with substance abuse issues, who has the potential for a relapse, and also where alcohol is concerned […] But it doesn’t seem to be the case here, […] so far it’s working, so far [the mother] is winning, which is great.”
>
> *(Interview 14; GP, Family 34; 7 month old child)*
>
> “But I think everything is settled now. So I’m pretty happy things are stable at this point of time, but it is a never-ending story so we need to keep an eye open for that.”
>
> *(Interview 15; GP, Family 36; 9 and 11 year old children)*

Without exception, participants identified neglect and emotional abuse as the main concerns when I asked what they needed to “be vigilant about”. Sometimes this neglect and emotional abuse was explicitly named:

Interviewer: “What are your concerns about? What is it that you envisage might possibly happen?”

Respondent: “Neglect really. I think with chaotic lifestyles that the child may become… well just not be cared for adequately. […] Parents who become impoverished because of their drugs using behaviour are at just that much more risk of physical neglect of not feeding the child, not caring for the child, not changing its nappy, of not… and to an extent emotional neglect as well, just that there’s not enough parenting input.”

(Participant 14; GP, Family 34; 7 month old baby)

“The problem is with the domestic violence. I’m not worried about the children whether they will be abused physically, I’m worried about the emotional deprivation rather than… the neglect rather than the abuse.”

(Participant 15, GP, Family 36, 2 children aged 9 and 11y)

Other times, neglect was implicit in the ruling out of physical abuse and the description of the poor outcomes that the participant predicted for the child:

“it is a fairly controlled situation, it is not an out of control situation, it’s contained as it were, but they are both functioning at quite a low level so I don’t think that the child is going to be beaten up, I do think that she, when she goes to nursery her speech, her speech isn’t going to be good, she will be behind developmentally, that she is missing out on a crucial period of her development […] it’s a sort of low level parenting issue”

(Participant 0, GP, Family 1, 1y old child with older sibling)

The perceived impacts of the neglect and emotional abuse were sometimes described as immediate and physical, such as young babies not being fed and more often, concerned the child’s emotional and physical development in young childhood.

Appendix 6.2: Full description of an "on the edge" narrative

Uses participant's own words

"This other [family]...is a vulnerable family, I think we recognize them as a vulnerable family. It's complex, um, and this is a little boy who is, um, really could have picked several of the children really, ah, but this little boy is four and, ah, he's in a family in which there are, I think, um...one, two...there's two brothers, older brothers, I think there's an older sister, there's a very much older sister who's just had a baby, they all live in the same house with their mum and dad […]. He's got, ah...I think he has problems with bed wetting and soiling actually and, um, he's also got a squint which, um...which isn't bad but the mother's repeatedly failing to get him along to appointments and that kind of stuff and, ah, he's kind of like...they're...they're...they're known to social services now, a child in need...he's a child...child in need, um, but they're...they're very difficult because they seem...the magnitude of their problem as a family can seem overwhelming really. Um, just every one of the children has a problem which of its own in a family would be a problem, and yet, they seem to have them all in...under one roof.

Interviewer: Are these medical problems?

Medical problems...medical and behavioural problems, that kind of thing, mental health problems […] The older sister is sixteen, she's now got her own baby and they've...they'd have to have a room in the house, so I think he shares with two other siblings and the brothers are in another room […]. I mean, all of the kids have got problems of some sort or another and the parents have their own problems. The mother's had a stroke and the father's had a heart attack and...[…]

Unless something is done soon [about the squint] he's going to lose his eye, […] we're not talking about surgery or anything, we're just talking about patches and covering and making sure he uses the eye and that kind of stuff[…]

Participant 5, GP, Family 15, five children aged 4-16y

[…] signals omitted text and [ ] signals paraphrased text.

“on the edge” families

The second most common story was one about families who were balancing precariously “on the edge”.

> “ […] you think ooh, it wouldn’t take much just to push them over the, you know…..”
>
> *(Participant 1, Health Visitor, Family 4: six children aged 2-18y)*

> “That kind of just underlying feeling that there’s...it’s all a bit...on the edge.”
>
> *(Participant 7, GP, Family 18, 13y old with 2 younger siblings)*

> “Anything like a tipping point as I said, illness or another child, something could tip the balance against the child”
>
> *(Participant 15, GP, Family 35, 2 year old child)*

Parents of “on the edge” families were described as failing to set boundaries for the children, failing to take children to school or feed them suitable food and failing to follow medical advice for the children or take them to medical appointments, with potentially very serious consequences for the child’s development, health and long-term future. As with “stable at this point in time” families, the participant’s concerns centred around physical or medical neglect and/or emotional abuse, largely named but sometimes implicit in their descriptions.

> “And the main concern we had was of neglect. And there were a number of demonstrations of that neglect manifest in behaviour changes in D and Ty, both boys.
>
> Interviewer: How old were they?

And they would've been three and four at this time. And they were allowed to run around unsupervised and they were also left for extensive periods in the care of their older siblings. And over time it became fairly clear that the large part of the care burden fell on the 12 and 13 year old girls in the family […]. So I think that he's likely to grow up – there will be some element of cognitive delay because he's not being stimulated particularly appropriately."

(Participant 4, GP, Family 13, four children 3-13y and six older siblings)

Clearly this girl, at 13, was out... that's probably 15 miles away, at two or three in the morning, getting drunk, you know, so that starts to feel quite neglectful. […] I mean obviously, […] kind of being drunk, is in itself a risk […] whether she gets into drugs and all the rest of it, if that's easily available there, whether she, like her mum, gets pregnant very early, umm"

(Participant 7, GP Family 13, 13y old with 2 younger siblings)

I mean, they're here, they're alive, but you know -- and that was an -- I think it's been terrible neglect really. […] And they are living this entirely dysfunctional mess of a life. […] She's not got a GCSE to her name. She's not been to school for two years. You know, what future has she got now?

(Participant 10, GP, Family 26, 16y old child with two younger siblings)

Where neglect was not named, concerns about neglect could be inferred from physical descriptions of the child or children:

"the kids were unkempt and the mum was sometimes a bit smelly."

(Participant 2, GP, Family 7, 2 children aged 2 and 3y)

"it was a cold day, and the little girl was freezing and, um, she's got these very red checks and red hands […] she did look miserable and she was crying an awful whining sort of a cry."

((Participant 0, GP, Family 1, 13m old child)

Or from the descriptions of children as not properly supervised:

> "... children up late and playing in the, you know, in front of the flats with no parental supervision"
>
> *(Participant 1, health visitor, Family 5, 4 children under 6y)*

> "…and they were allowed to run round unsupervised."
>
> *(Participant 4, GP, Family 13, four children 3-13y and six older siblings*)

Or from reports of inadequate medical care:

> "She has a particular [medical] problem which requires regular management. And we've had fairly string suspicions that whilst she's under the care of mum she doesn't have her regular [medical] treatment."
>
> *(Participant 4, GP, Family 13, four children 3-13y and six older siblings*)

> "…but his main problem is that she has a visual problem as well. He has a very severe squint and, erm, he's very short sighted so he wears glasses and there's issues, his glasses are constantly broken. Erm, mum's meant to be patching one of the eyes but she doesn't and misses lots of appointments at the children's hospital."
>
> *(Participant 5, GP, Family 15, five children aged 4-16y)*

Participants were able to described family life in detail, including housing conditions, employment status and other health and social problems for multiple family members.

The multiple, complex and chronic problems in these families, included: parental alcohol abuse and/or mental health problems, overcrowding, unemployment, financial problems, parental health problems and child health and behavioural problems. Participants mentioned possible parental drug use and suspected domestic violence but, unlike the "stable at this point in time" families, these issues remained in the background of the stories and problems with health, money and housing dominated.

Stories about "on the edge" families were typified by accounts of historical and intermittent intervention from child protection services which were often portrayed as inadequate, with varying degrees of explicitness.

> "The older children, when they were younger, there was a child protection plan. So they are …so they're a family that are known to the services."
>
> *(Participant 1, Health Visitor, Family 4, Six children two aged under 4y and four teenagers)*
>
> "Over the ten year, eleven year, twelve year period, social services involvement and therefore official child protection involvement has been variable […] there have been conferences held and the various children have been put on the child protection register, as it was then […] – and then taken off again and they're currently all off the register."
>
> *(Participant 4, GP, Family 13, four children 3-13y and six older siblings)*
>
> "umm, and she was on the child protection register when she was little, probably pre-birth I should think […] Social services have been involved with it a lot over the years, so they've... but it's always been these kinds of one off kind of encounters."
>
> *(Participant 7, GP Family 13, 13y old with 2 younger siblings)*

Many of the children were described by the participants as 'vulnerable' and as having current involvement with child in need social care services.

The perceived consequences of the neglect in “on the edge” families included short, medium and long term impacts. As the quotations above illustrate these included concerns about behavioural changes in the short term, child development in the medium term and risky behaviour and social and economic prospects in the much longer term.

Appendix 6.3: Full description of a "was it, wasn't it?" narrative

Uses participant's own words

"Yeah. The first family...um...a mother with two little..actually, no, thinking about it...three little boys and on-going concerns with them. Um, one is a baby, he's about five months, one little boy is about two, and the other one is three, um, and, um, there's a dad as well who is around...works away a lot but is around as well and they've been a family of concern because, um, when the...before the baby was born, there was a child who...one of the boys was under one, and the other was under two and [the health visitor] was concerned about the fact that every time she saw the...the one who was about one, he always seemed to have quite a few bruises, not...ah, none of the bruises were of themselves suspicious. They were all in places where you might expect to see bruises but she just was concerned that every time she saw this little one, he had bruises and, um, she was uncertain, really, whether it amounted to anything or not and, um...and I think one of the difficult things was that when I then saw this baby...uh...probably just...just a bit more than one, he was at an age where he was ambulatory so it wasn't surprising to have bruises. He just seemed to have quite a lot of bruises and we had to make a difficult decision at that time to actually refer him into social services […] The mother said it was rough play. These two were always...and they were fairly boisterous in the consulting room, but, um, we decided to refer them into social services and the mother was obviously very unhappy at the time.

So, um, it was all pretty fraught really, and, um, they went up to the hospital escorted by the social worker [to see] the designated consultant for child protection and she had a look and, um, she was concerned about the extent of the bruising, because it was either...it's either a non-accidental injury and I think we all had agreed in the end it wasn't but there were issues around supervision of the children."

(Participant 5, GP, Family 14, three children 5m-3y old)

[…] signals omitted text and [ ] signals paraphrased text.

“was it wasn’t it”

The third narrative that emerged was one in which participants described a situation in which they were trying to rule out the possibility of sexual abuse or deliberate injury. In all cases of this type of concern participants described uncertainty about “whether it amounted to anything or not” and explained how they did not have a strong belief that the child had been deliberately injured or sexually abused. They describe having just enough concern to take further action:

> “I thought they were probably accidental, and then because they... you know, they weren’t obviously cigarette ends or anything like that, they were thin burns […] but then when I saw their notes, something in my mind thought hmm... was it, wasn’t it, or... and it was the whole business about them DNAing [Did Not Attend i.e. missing] the follow-up...and then seeing the notes that the other children had been... in those days it.....was called on the child protection register. And that sparked my awareness and level of “oh crikey”. So I rang and asked if I could see the child again”
>
> *(Participant 11, Practice Nurse, Family 27, 2y old and older siblings)*
>
> “Actually at the end of the day I really wasn’t...I didn’t have a high level of concern that C was being abused...C was being abused by her, um...anyone in the family. I really didn’t have high suspicions over that. Um, so then I had to, um...then I had to explain to C’s mother and father that I had to refer to social services.”
>
> *(Participant 8, GP Family 20; 8 year old)*

In all “was it, wasn’t it?” stories, the participants told me that after varying amounts of time, ranging from a few days to over a year, the participants reached the conclusion, often in conjunction with social care, that the child was not likely to have been abused or be at risk of abuse.

> They did bring the child down, and, […] the burns were healed, and the child was perfectly happy and, erm, and I was satisfied with myself that, you know, that was perfectly ok.
>
> *(Participant 11, Practice Nurse, Family 27, 2y old and older siblings)*
>
> "I mean in the end it was all quite innocent I think, erm, everybody was satisfied with what was happening and nothing untoward was going on..."
>
> *(Participant 12, GP, Family 32, age of child not given)*
>
> "The social workers felt, after discussion with the parents, that [the child] was not likely to be at risk of abuse. So we were all agreeing that by that point."
>
> *(Participant 8, GP, Family 20; 8 year old)*

In the two stories of possible sexual abuse, the concerns and the participants' story ended with the (probable) ruling out of sexual abuse. However, in the three stories of injured children, participants told me that there were on-going concerns about parental supervision.

The perceived impacts of the possible abuse were largely immediate and centred round physical injury and, in the case of sexual abuse, psychological distress.

Appendix 6.4: Full description of a "fairly straightforward" narrative

Uses participant's own words

"…when I see something that's obvious, I saw a child recently with what appeared to be a new fracture and referred it, you know, kind of, do not pass go, straight to A&E, and you know, and... and then it moves on, you know, and then you know, that the right things have happening... happened, and in a way that kind of seems fairly straightforward."

(Participant 7, GP, Family 38; no details of age given)

[…] signals omitted text and [ ] signals paraphrased text.

“Fairly straightforward”

The fourth narrative was one in which the case was described as “fairly straightforward”. These examples were characterised by “obvious” (Participant 7, Family 38) or “barndoor” (Participant 10, Family 26) child protection concerns, a high level of suspicion and decisive referrals to secondary care or social care services. These stories were told less frequently than any the other type of story. The concerns were only mentioned to me in passing and as a contrast to the families that participants spent most time talking about:

> “when I see something that’s obvious, I saw a child recently with what appeared to be a new fracture and referred it, you know, kind of, do not pass go, straight to A&E, and you know, and... and then it moves on, you know, and then you know, that the right things have happening... happened, and in a way that kind of seems fairly straightforward”
>
> *(Participant 7, GP, Family 38; no details of age given)*
>
> “Well, there’s one that’s fairly straight-forward. I did the...you know... the...the parent...the mother, um, disclosed some domestic violence and so I...it just happened yesterday and so it was just about making sure she contacted the police and that they go through child protection in that way. I don’t think there was that much to it, actually.”
>
> (Participant 8, GP, Family 21; no details of age given)

Another participant used the word “straightforward” about a case and then went on to describe the teenage child and what happened in depth. Unlike the other “fairly straightforward” families, this case was described in detail but, it was similarly offered as a contrast to the other families she had told me about. The perceived straightforwardness of the case was connected to the limited length and depth of the participant’s involvement with the child: the participant had a one-off contact with the teenager and this case was “much shorter”.

There was no detail in these cases of perceived impact of abuse on the child, though some children were described as presenting with injury and we can infer that in these case there were concerns about immediate and physical danger.

Appendix 6.5: Narratives outside the typology and which changed over time

The stories that participants told me were rich and complex and their involvement with the families had often lasted many years. Some of the participant's descriptions of the families incorporated more than one of the narratives I identified. The most common combination of these narratives was in descriptions of families which moved from "was it/was't it" or "on the edge" to "stable at this point in time" stories. In all of the cases of "was it, wasn't it?" families, the sexual or physical abuse was eventually ruled out, at which point participants began to talk about the families in terms of "stable at this point in time" or "all settled down now" but requiring extra vigilance for possible neglect (lack of adequate supervision). One "on the edge" story was resolved into a "stable at the moment" story by securing a child protection plan for the child and in another case, an "on the edge" story began to resemble a "straightforward" case with the GP reporting limited involvement after a referral to social care.

Families outside the typology

There were seven descriptions of families (six families, described by seven participants) where the stories did not fall into the four types of narrative that were generated from the rest of the data and where the characteristics were not similar enough to each other to generate a cohesive new category. Two cases did not concern children at risk of abuse from parents (or parent-figures). One of these was a mother of an eight month old baby who committed suicide (Interview 11; Family 28) and the other was a case of school bullying where the participant referred to Child and Adolescent Mental Health services (Interview 3; Family 11). One GP told me about his concerns about an infant with failure to thrive but the participant had difficulty remembering details of the child or concern and there wasn't enough detail to characterise the story:

> "And I've no idea – no recollection of the event as well. You know, everything is just a bit vague"
>
> *(Participant 3, Family 10, Child aged under 1y)*

Two stories, told by three GPs, focussed on families about to go through care proceedings, where there was no longer hope for parental capacity to look after the child (Interview 7 and 13, Family 17). Participant 7 described how he had spent the last two years observing a mother:

> "agreeing to a [child protection] plan and then doing nothing to actually realise it."
>
> *(Participant 4; Family 12; 2 year old child)*

For the remaining family, the participant discussed multi-agency working with social care but gave little detail about the family or her own relationship with them (Interview 7, Family 19).

Appenidix 6.6: 'Monitoring' (full details)

This section contains the fully explored theme of monitoring which is summarised in Chapter 6, Table 6-4.

GPs described how they monitored families who had prompted concerns more closely than other families:

> "I think we'll probably always be a bit more vigilant and little bit more worried"
>
> *(Participant 14; GP, Family 34; 7 month old baby)*
>
> "I can keep a watchful eye on the older two girls"
>
> *(Participant 0, GP, Family 3, 4y old child with two older siblings*)
>
> "I'm not going to close my eyes but just to keep an eye to make sure this is what the case is"
>
> *(Participant 15, GP, Family 36, 2 children aged 9 and 11y)*

Keeping a close eye on families ('monitoring' them) was a frequent feature of the narratives depicting "stable at the moment" families and, an occasional feature of "on the edge" families.

There were several ways in which GPs described monitoring these families. The first was to use routine or usual health appointments for the children:

> "Um, the children didn't...never seemed to have quite so many bruises whenever I'd seen them again because obviously every time I'd seen them, it's been on my mind and obviously when I did the six-week check on the little baby, we had a good look at him but he...he seemed absolutely fine."
>
> *(Participant 5, GP, Family 14, three children 5m-3y old)*

GPs acknowledged that this kind of monitoring could only be done if trust had been established and parents could be relied upon to bring children in to the surgery:

"I can keep a watchful eye on the older two girls because I think they will bring them into see me now [now that trust has been established] too"

(Participant 0, GP, Family 3, 4y old child with older siblings)

Monitoring was also facilitated by other family members, often maternal grandmothers, who presented to the GP to and disclosed information about family life and parenting behaviour:

Respondent: "And the mother just goes off at night, got to go, I got a call from my boyfriend, I'm going clubbing. She'll leave the child."

Interviewer: And how do you know about this?

Respondent: Yeah, from the great grandmother. Always great grandmother comes."

(Participant 15, GP, Family 35, 2y old child)

In this case, a decision was taken based on the information offered by the grandmother. In the first case (Participant 15, Family 35), the GP explained how he was satisfied that the child was ok because the great-grandmother was taking responsibility for his care. This GP was monitoring the great-grandmother for signs of ill health or of struggling to cope with a toddler because he planned to recommend that the child be removed from the mother's care if she were in sole charge.

When participants were confident that the family would come to them for help and were likely to voluntarily offer information GPs, GPs seemed to feel comfortable with the role of monitoring social welfare concerns in families.

In addition to consultations in the surgery, GPs used home-visits to monitor concerns. Two GPs from two practices told me that they routinely did postnatal home-visits about two weeks after the birth for all their families. One of the GPs explained how she had specifically chosen to go and do this home-visit so that she could follow-up concerns about sexual abuse of the teenage mother:

"Um, and she had the child, and...and again I went to do that post-natal visit at home because I thought, well, it could be interesting to see what's happened."

(Participant 6, GP, Family 15, describing 15 year old girl with four younger)

A further strategy for monitoring families was to use the electronic health record to check subsequent presentations. Participants cited both presence and absence of presentations as potentially concerning in these families:

"Respondent: And I've checked up on the notes every so often as well just to make sure that there's been nothing more that's come up."

Interviewer: "And what kind of things were you looking for in the notes?"

Respondent: "Well just checking to see if mum, if the grandma had come back in you know with any injuries or anything like that, or if the girl had come back in. Saying you know, I'm worried or anything like that."

(Participant 13, GP registrar, Family 33, unborn child)

"I know that, I have checked the notes several times and she hasn't been in with that child since and I suspect that she is just avoiding services."

(Participant 0, GP, Family 1, 1y old child with older sibling)

As well as monitoring families through consultations and home-visits, participants also used lack of expected contact with themselves or other healthcare services as a way of monitoring families. Six participants believed that missed appointments with health services in families with known concerns were likely to be a sign of escalating problems. Participant 4 (Family 13) described how the practice had agreed to notify social care of all missed appointments for a family where medical neglect was a particularly concern, though he was not sure how social care were responding to this information. Participant 6 explained how she was developing a system for her practice to capture all missed primary and secondary health care appointments in vulnerable patients. Vulnerable patients would include "anyone under sixteen, um, plus, say, alcoholics, people with dementia, you know, all of the other ones you'd normally

expect." If patients missed appointments they would receive a phone call from the GP which could be followed-up with a letter if necessary and repeated or worrying missed appointments would be routinely discussed at the primary care team meeting.

Primary health care team meetings were also used more broadly to monitor welfare concerns in families:

> "I'll probably discuss it at the primary health care team meeting next Monday […] that's the way we sort of monitor these sorts of families"
>
> *(Participant 5, GP, Family 15, 4y old child with four siblings)*

This was achieved in two ways. First, by anticipating important or stressful points in a family's life, such as birth of baby and/or monitoring adherence to treatment that could impact on parenting:

> "when we met regularly as a whole team, the whole practice, we were [..] recognising for example that the mother was nearing term, that the parents were complying with [methadone] treatment and all was going well."
>
> *(Participant 14; GP, Family 34; 7 month old baby)*

Or participants shared information with other professionals at the meetings, usually the health visitor, who was seen by GPs as an essential facilitator for monitoring via the vulnerable families meetings:

> "Of course [we ask health visitors what they know] at the child protection meetings we have on a regular basis at the practice if it's starting to get more formal. Or you might just say, "Is anyone worried about this family?"
>
> *(Participant 2, GP, Family 7, 2 children aged 2 and 3y)*

In summary, monitoring of safeguarding concerns was seen as an accepted part of the GP role in families, especially for those participants who saw the GP as a trusted ally and were perceived to be engaged. Strategies for monitoring included using routine consultations in the practice or at home by the child, parent or wider family,

encouraging disclosure of information by family members, use of electronic records to check subsequent presentations and using the primary health care team meetings, especially the wider knowledge of the health visitor. The purpose of monitoring was to make decisions about whether or not there was information that needed to be passed onto social care services, who were usually reported as working closely with these "stable at the moment" families.

Appendix 6.7: 'Advocating' (full details)

For "on the edge" and "was it wasn't it" families, participants described how they made a case on the participant's behalf to other agencies. This can be seen as 'advocating' for the families. Infrequently participants also described advocating for "stable at the moment" families.

One type of advocacy was to intercede on behalf of participants for improved housing or to support requests for state benefits. Not only did this have the purpose of developing trust in the relationship between GP and parents but at least one GP was also motivated to improve the overall quality of life of the family, believing that this would have a direct impact on the concerns about parenting:

> Interviewer: "And what do you think is the best thing that could happen for this family if you could, you know, give them anything?"
>
> Respondent: Um, they need a bigger house. They need a bigger house. […]Um, I always think if...if...if...if the parents had decent...decent jobs and decent houses, then a lot of problems probably get...get sorted out."
>
> *(Participant 5, GP, Family 15, 4y old child with four siblings)*

In this case, the Participant 5 imagines that the medical neglect of the child's squint might be alleviated by reducing pressure on this chaotic family caused by some of the other problems such as housing, serious ill health and unemployment:

See Chapter 6, section 6.4.1.2 for a more in-depth discussion of supporting benefits claims and how this was used to develop trust.

A second type of advocacy was for GPs to intercede with social care on behalf of the child or family when they believed that social care was not providing an appropriate service, as was often the case with "on the edge" and "was it, wasn't it?" families (see Chapter 6, section 6.2.5.3 for a detailed discussion of the perceived appropriateness of social care services for these families). One GP described how she felt she had to

“stand up and shout” for the children in a family in order that they be given priority for services and not be overlooked:

> “you always get the feeling the social services are overwhelmed and they have a lot of cases to deal with. And, you know, to a certain extent, if no one is batting on their door and the case is just left in a file until they get picked up again or until somebody starts shouting about them, you know, another one will always take precedence. And I think, you know, you've got to stand up and shout for people, because sadly, in some ways, that's the way they actually begin to take more notice.”
>
> *(Participant 10, GP, Family 26, 16y old child with two younger siblings)*

This need to intercede with social care for the children was seen as greatest in the “on the edge” families who were not perceived to be such “barndoor” or “obvious” child protection cases but who in many cases, as with Family 26, were perceived by the participants to be suffering “terrible neglect”:

> “I mean, there's the barn door obvious ones where, you know, you can't help it. But all of these ones in the middle, you sometimes just think, you know, someone has got to stand up and take notice of this”
>
> *(Participant 10, GP, Family 26, 16y old child with two younger siblings)*

For “was it, wasn’t it?” families, the GPs tended to describe how they interceded to reduce what was perceived as unnecessarily “heavy-handed” or insensitive approach to the situation. Participant 8 (Family 20) described how she called social care to and asked the duty manager to allocate a female rather than a male social worker to come to talk to the child (in a case of possible sexual abuse). In these cases, the GPs described how they encouraged the parents to comply with and engage with social care. GPs did this with the aim of preventing things “getting worse” or “more difficult”. There was an implied aim of reducing or avoiding a coercive approach from social care by helping parents to demonstrate that there was opportunity to work under voluntary arrangements:

"…just trying to encourage her that she needed to...just to be open with everybody and keep engaged in the process or it would become even more difficult and just trying to sup...support her to keep in there with the social workers and not...try not to get too cross with them Um, and I think I managed to do that, um, and in the end they did go to a...some kind of hearing. Um, local authority...something came out of it saying local authority has been impressed by the degree of cooperation and work with professionals undertaken by the parents. They did manage to engage with the social workers and I think I was trying to help them do that really."

(Participant 8, GP Family 20; 8 year old)

"we decided to refer them into social services and the mother was obviously very unhappy at the time, walked out of surgery, took her kids with her. I met her going to the car park and said, "Look, you know, if you...if you leave now, social services will come over to your house with the police, it will just get worse. I know it's difficult. We've got to...we've got to get you to the hospital and get...you know, the social worker is going to come here and then take you to the hospital."

(Participant 5, GP, Family 14, three children 5m-3y old)

In summary, Participants used their position as doctors to support benefit claims for patients with the aim of mitigating neglect by reducing other stressors in the family. The participants also interceded with social care services on behalf of children and families who were perceived to be receiving an either insufficient or exaggerated response from social care or where these services were perceived to be insensitive. Finally, participants encouraged "was it, wasn't it?" families to demonstrate cooperation with social care with the goal of proving that the family should receive supportive and voluntary intervention rather than more coercive measures.

Appendix 6.8: 'Coaching' (full details)

GPs described how they attempted to shift parents' mindsets about their problems, encouraged parents to take responsibility for their problems and tried to motivate them to change behaviours that were harmful to their children. This 'activating' of parents can be seen as a type of coaching.

There were two main aims of the GPs coaching. First, they described their role in getting parents to change their mindset about the problem and secondly, they encouraged parents to change behavior.

GPs wished to change parental mindset by encouraging parents to understand that there was a problem with their parenting. This was described as a difficult task:

> "Well I think the difficult thing was trying to, erm [sighs] well make mum realise that there was actually a problem with the children [to] appreciate that the children needed looking after, shall we say, better..."
>
> *(Participant 12, GP, Family 30, 2 children aged 6 and 12y).*

It was a task that two GPs described as attempted but not achieved:

> "I would have liked to have seen them realising that their ability to parent children was not enough to cope with the children that they had. So they kept having children even though they were unable to raise properly the children that – the existing children that they had."
>
> *(Participant 4, GP, Family 13, four children 3-13y and six older siblings)*
>
> I think for her it's a matter of trying to persuade her that stopping drinking is a good idea....erm, and... and... and I really don't know how you do that, because at the moment she doesn't seem to believe me"
>
> (*Participant 12, GP, Family 30, 2 children aged 6 and 12y).*

But a parents willingness or ability to recognize that there was a problem seemed to make the difference between a hopeful and a hopeless situation. Participant 12

described how he thought that the children in Family 30 would never be reunited with their mother because she "didn't believe" that her drinking needed to stop: "the chances of her getting them back [from foster care] is slim to be honest" whereas, the same GP felt optimistic about Family 31 because the mother had acknowledged that there was a problem, which he saw as the first step in intervening to improve the situation:

> "but it does seem that she's beginning to get to the stage now where she appreciates herself that she needs some help [with her drinking], which is, you know, I was quite pleased when that happened because I thought that was a major advance really. And I think we actually might get somewhere in terms of making her better."
>
> *(Participant 15, GP, Family 31, children 3 and 7y)*

In order to have a hope of changing parental mindset, GPs saw that the parents needed to be engaged with primary care and to see them as a 'trusted ally'' (see Chapter 6, section 6.4.1 for more discussion on how GPs positioned themselves as a 'trusted ally'):

> "So both of them are talking to me, which means that they both have confidence in me and I feel able to say a few things that hopefully may change their life and they maybe happy together."
>
> *(Participant 15, GP, Family 36, 2 children aged 9 and 11y)*

Encouraging participants to change behavior was seen another part of coaching parents:

> "I was mainly supporting, trying to urge her to change behaviours or look at different ways of thinking about things"
>
> *(Participant 2, GP, Family 7, 2 children aged 2 and 3y)*

This too was seen as difficult:

"But behaviours are very difficult to change"

(Participant 2, GP, Family 7, 2 children aged 2 and 3y)

Or even impossible:

"It reflects, this is what they are like and can you change really what...what they're actually like?"

(Participant 6, GP, Family 15, family of 5 children)

Participant 4 saw the difficulty in successful coaching as due to GPs' reliance on one single tactic: supportive encouragement, which was not always effective:

Interviewer: "And if she didn't – if she then hadn't done what she was supposed to have done by the time she was supposed to have done it?"

Respondent: "Well, I can simply reflect that back to her. I have no teeth to then in any way punish her or hold her otherwise to account. All I can say is I'm disappointed that you haven't done this. I wouldn't particularly want that power, I'm just – I'm pointing out that the techniques that I would use to try and engage her more strongly have no teeth behind them. Doctors don't go about punishing patients by and large. We rely on our encouragement and then a sort of heavy sigh and well."

(Participant 4, GP, Family 12, 2.5y old)

Participant 4 held up Family 12 as an illustration that GP involvement in safeguarding is not possible for every family:

"I sit here as a leader in the practice and in the wider medical community as illustrative of engagement in safeguarding is a good thing and will lead to improvement. And actually I'm aware that this family illustrates that not everybody gets better with caring doctors supporting involvement."

(Participant 4, GP, Family 12, 2.5y old)

Like successful monitoring, successful coaching was seen as reliant on parental engagement and willingness to change. This makes clearer why the GPs in my sample focussed on developing trust with parents and why their narratives were dominated by accounts of families who were engaged and help-seeking

Appendix 6.9: 'Opportune healthcare' (full details)

Two GPs spoke of how they undertook opportune healthcare for children whose families who were "on the edge" or "stable at this point in time" when their parents came in about something else. This opportune healthcare was in place of missed routine checks or preventive care, such as developmental checks, well-baby checks or immunisations. The GPs acknowledged that this care had to be done then and there as these families could not be relied on to come back and have it done at a later date:

> "'oh, and while you're here, we'll do that developmental check that she is overdue'"
>
> *(Participant 0, GP, Family 1, 1y old child with older sibling)*
>
> "So I ended up saying where did she go to get the baby weighed and the baby's six weeks old and she never had the baby weighed before in the baby clinic. So we went along and met the health visitor and got the baby weighed and stuff, […] so I have other mothers who forget their books [Personal Child Health Record], so fair enough, you know, bring it...pop it in another time, or...or getting your baby weighed and go along to the health visitor. I knew with her it would have to be a question of saying, "Let's get you along to the health visitor; here's the health visitor..."...
>
> Interviewer: You had to take her?
>
> Respondent: yes, in case she said, "Oh, I'm off, I'm going to go home" or felt that she was...and felt bad about not getting the baby weighed. There's so many reasons why she might not have wanted to get the baby weighed, so I thought it was an opportunity."
>
> *(Participant 5, GP, Family 15, describing 15 year old girl (with a baby) from a family of five)*

This particular example of opportune health care relied on an accessible and willing health visitor in the building. In addition, Participant 0 drew attention to the fact that

this process of opportune healthcare was facilitated by having leverage from being able to offer something that the parent wanted (see Chapter 6, section 6..4.1.2 for more on leverage):

> "'Oh by the way, you want that sick note, I'll just immunize your child'."
>
> *(Participant 0, GP, Family 1, 1y old child with older sibling)*

Appendix 6.10: Referral to other services (full details)

Participants spoke commonly about referral to social care services and to paediatric services. Each is discussed in turn below.

Social care services

Referral to children's social care was common in the narratives about "fairly straightforward", "was it, wasn't it?" and, to a lesser extent "stable at the moment" families. There were two pathways to referral to children's social care portrayed in the interviews.

First, "fairly straightforward" families prompted immediate referrals to social care from GPs. These cases were typified by a high certainty that children's physical safety was threatened (physical abuse or domestic violence in the household) and that social care would respond appropriately (see Appendix 6.4 above for more on "fairly straightforward children and the perceived appropriateness of involvement by social care).

The second pathway to referral to social care followed GP involvement of a health visitor and was a feature of narratives about "was it, wasn't it?" families and "stable at the moment" families. GPs described how they ask health visitors to follow-up a concern so as to confirm the worry or provide reassurance:

> "...because there were lots of things I wasn't happy about and, um, I wrote a little note to the health visitor as well […] and I said 'oh, please, you know I am not happy, please would you go and see her again or make contact again'."
>
> (Participant 0, GP, Family 1, 1y old child with older sibling)

When health visitors confirmed a GPs concern, it became a trigger for a referral. This referral was usually to social care, though it could also be to the safeguarding lead in the practice as an interim step:

> "I had a word with the health visitor. And she said, funny enough she felt exactly the same when she went to visit. And then we thought the best way

forward was to get [safeguarding lead in the practice] to assess the child and so we did do that."

(Participant 3, Family 10, Child aged under 1y)

Interviewer: "And what tipped...what do you think tipped you over [into making the decision to refer to social care]?

Respondent: "Mm, I think...well, um, the health visitor's anxiety, she was worried."

(Participant 5, GP, Family 14, three children 5m-3y old)

Corroboration by a health visitor was seen by one GP as prerequisite for a referral to social care that that did not involve physical abuse, because of the high thresholds in children's social care for investigating referrals where the child's safety was not immediately threatened:

Interviewer "and what, what would have to change for you to think that you would have to involve social care?"

Respondent "um, I would have had to have seen some evidence of physical abuse or I would have had to have got back from the health visitor that she wasn't happy either."

(Participant 0, GP, Family 1, 1y old child with older sibling)

The opinion of school nurses and midwives were also used by GPs, though to a lesser extent, to scale concerns up or down and reach decisions about referral to social care (or not) where children did not fall into the 0-5y age bracket (Participant 13, GP registrar,

Family 33, unborn child and Participant 15, GP, Family 36, 2 children aged 9 and 11y, respectively).

In summary, health visitor and, to a lesser extent, midwives, school nurses and practice safeguarding leads, were used by GPs to scale concerns up or down and make

decisions about whether or not to refer to social care. This was the route to social care referral in cases of neglect and emotional abuse ("stable at the moment" families) and where there was high uncertainty about possible physical abuse ("was it, wasn't it?" families).

Paediatric services

Four GPs described making referrals to paediatricians due to maltreatment-related concerns (Participant 2, Family 8; Participant 5, Family 14; Participant 8, Family 20; and Participant 12, family 32). In all four cases, the GP sought a second opinion about the probable cause of injuries (N=1) or genitourinary symptoms (N=3) and, in keeping with this, all four cases were from "was it, wasn't it?" families.

In these four cases, the decisions to refer to paediatricians did not seem to be a difficult one for the GPs - it was not something they deliberated about or for which they consulted a colleague or other professional. In two cases (Family 5 and Family 8) the referral to the paediatrician was accompanied by a simultaneous referral to social care services (there was no mentioned of a social care referral in the brief narratives by the other two GPs).

APPENDIX 6.11: 'Working with other agencies' (full details)

Working with children's social care services

Strategy meetings, case conferences and child protection plan review meetings

GPs commonly stated that they infrequently attended joint child protection meetings with social care and cited time, conflicting priorities and period of notice as barriers to attending:

> "Because we do get invited to a lot, well, most or all of the case conferences, but sometimes with not very good notice. So you might get a note saying there's a case conference on Thursday at twelve and you've already got a surgery booked. So it is quite difficult."
>
> (*Participant 10, GP, Family 26, 3 children 9-16y)*

> "Over the years I've attended very few case conferences. It's a question of well, the life – the job seems so intense that I'm not sure I do have the time to do it because of the time it takes out of seeing my other patients."
>
> *(Participant 2, GP, talking generally)*

There were several factors that seemed to motivate GPs to attend case-conferences. Sometimes they felt that they knew the families involved and had something meaningful to contribute:

> "there's a couple of families who I always try and get to, because I do feel that I have quite a lot to say. You know, the ones that you really feel you know more about than the people you maybe just met once or twice, so you're not gonna add very much."
>
> (*Participant 10, GP, Family 26, 3 children 9-16y)*

A meaningful contribution was allied to medical problems in the parent or children on which GPs felt they were the only ones who could advise:

> "I went and I was able to be there for the whole case conference, which is relatively unusual, I would say these days, for me to be able to get to case conferences, even if I know somebody well or are concerned about them. […] I think social services were quite dependent on us to be saying, these I think are the issues, the alcohol, the learning disability, the previous children, and I think if... if we hadn't been feeding in the information that we thought there was a learning disability there as well, then they might have wasted a lot of time".
>
> *(Participant 7, GP, Family 18, unborn baby and previous children in care)*

Or because GPs had accepted responsibility because the meeting followed from their own referral:

> "Respondent: Um, well, initially there was, um...there was a child protection case conference initially and I went along to that. I don't get along to hardly any, um...

Interviewer: What made you go to that one?

Respondent: Because I was the one that put the referral in. Otherwise we never...we never get along."

(Participant 5, GP, Family 14, three children 5m-3y old)

Or because GPs perceived a need to advocate for a child from an "on the edge" family who was not receiving the child protection services the GP believed they needed:

"And the ones for whom I feel I must go because I'm so frustrated that nothing ever happens that I need to go and, you know, fight my corner or fight their corner here and make sure my voice is heard."

(*Participant 10, GP, Family 26, 3 children 9-16y)*

GP frequently cited that they sent reports to the case conferences and child protection meetings that they could not attend and/or relied on health visitors to act as the health representative on their behalf:

"They [health visitors] represent us...well, they don't represent us, they are...they are a health representation at conferences and meetings and strategy meetings"

(Participant 5, GP, talking generally)

One GP described how her practice had successfully increased GP attendance at joint meetings by offering the practice seminar room for free to social care so that the meetings could be held on-site.

Wider working with social care

For wider working with social care, GPs were largely dependent on health visitors:

"Interviewer: Um, can you talk a bit more about how your role at...your role as a GP and, also of your primary care team as a whole, um, worked in relation to social care with this family?

> Respondent: I think most of the communication goes by health visitors I think we...we...we rely on them a lot. Um, they keep us abreast of things. …] Um, so, we...I don't think we have very little direct contact with social services really."
>
> *(Participant 5, GP, Family 14, three children 5m-3y old)*

GPs (and practice nurses) described how they relied on health visitors to convey information from social care to the practice staff via the vulnerable families meetings including the status of children as 'in need' and/or the content of child protection plans. Only in two narratives, did GPs describe on-going and direct involvement with children's social care. Participant 7 (Family 18) described how she had pressed social care for a parenting assessment of the family and had undertaken an assessment of learning difficulties in the parents and interpreted this in the context of parenting for social care. Secondly, Participant 2 (Family 12) described how he had gathered together all the information from health care services and interpreted it for a family in which maternal neglect had resulted in failure to thrive and developmental delay. In both cases, the GPs were the practice safeguarding lead and highly experienced in safeguarding and the concerns contained an important 'medical' element (learning difficulties and failure to thrive).

In summary, GPs described how they were largely reliant on health visitors and written communication for contact with social care. Where they did engaged with the wider on-going social care processes, it was in the context of knowing the families well, feeling as if they had a unique 'medical' contribution to make or as if the children needed someone to "fight their corner" because social care were not taking the concerns seriously enough.

Working with paediatric services

Only one GP (Participant 8) described working constructively with a paediatrician. Two GPs (Participant 5 and Participant 8) gave accounts where paedatricians had problematized the referring GPs continued response to the family and the concerns. The difference between the constructive and failed working with paediatricians

revolved around the professional trust and understanding. This is discussed in depth in Chapter 6, section 6.4 which describes facilitating and hindering relationships.

Appendix 6.12: 'Recording' (full details)

This appendix combines the sub-themes in interviews (Chapter 6) *and* development phase (Chapter 3)

Most of the findings about recording echoed those from the development phase of the study (Chapter 3, section 3.5.3). There were, however, two further themes that were new to the interview data: 'The changing nature of recording' and "nebulous concerns", which are described in detail below

The changing nature of recording

One GP participant suggested that the nature of recording was moving away from "vague" or euphemistic recording to more specific, structured and complete recording with increased use of Read codes:

> "In the past we've used sort of unwritten codes to say we've got concerns. […] Our child protection lead has now got a template [structured data entry form using Read codes] that we use - we code facts basically now."
>
> *(Participant 2, GP, talking generally)*

This opinion was seconded by one of the practice nurses:

> "because I think again in those days we were much more vague than we are these days."
>
> *(Participant 11, practice nurse, Family 27, 2y old)*

"Nebulous concerns"

Participant 7 kept returning to the same idea in her interview: that it was very difficult to capture "nebulous" concerns in the record, without which the recorded 'facts' are meaningless:

> "I don't know that anybody else, looking at this girl's notes, and seeing this episode of intoxication would... would really know what the significance of that was, just because it... it's sort of rather nebulous stuff that never has been

collected because it's all in my head. That kind of just underlying feeling that there's... it's all a bit on the edge".

(Participant 7, GP, Family 18, 13y old child)

This GP conceptualized "nebulous" concerns as "low-level" concerns about very inadequate parenting that persists over many years and which becomes worrying when seen as cumulative picture (Family 18 and Family 19). As such, these "nebulous" concerns are compatible with concerns about long-term neglect and/or emotional abuse, particularly in families perceived as "on the edge". Implicitly, Participant 7 suggests that it is most difficult to record concerns about long-term neglect and emotional abuse and that these types of concerns are particularly vulnerable to remaining "all in my head".

Appendix 6.13: Detailed results from literature review of parent, young person, adolescent and child view of the doctor-patient relationship in general practice

Included studies (ordered by first author, alphabetically)

1. Action for Sick Children. *First contact research survey*. London: Action for Sick Children, 2013.
2. Balding A, Regis D. *Young People into 2012*. Exeter: Schools Health Education Unit, 2012.
3. Boddy J, Statham J, Warwick I, Hollingworth K, Spencer G. *Health related work in family intervention projects*. London: TCRU, Institute of Education, 2012.
4. Cameron C, Bennert K, Simon A, Wigfall V. *Using health, education, housnig and other services: a study of care leavers and young people in difficulty*. London: TCRU IoE, 2007.
5. Chase E, Knight A, Statham J. *Promoting the emotional wellbeing and mental health of unaccompanied young people seeking asylum in the UK*. London: TCRU IoE, 2008.
6. Children North East, Streetwise. *Our Health, Our Voice* Newcastle: LINK, 2011.
7. Cossar J, Brandon M, Bailey S, Belderson P, Biggart L, Sharpe D. *'It takes a lot to build trust'. Recognition and telling: developing earlier routes to help for children and young people.* London: OCC, 2013.
8. Healthwatch Warwickshire. *Young People's experience of GP Services*. Warwickshire: Healthwatch, 2013.
9. French J, Gearty J, Cordle J, Lewis J, Bevan A, Starling B, et al. *Young people's views and experiences of GP services in relation to emotional and mental health*. Sussex: Right Here Brighton and Hove, 2012.
10. National Children's Bureau. *Teenagers' views on their health and local health services*. London: NCB, 2012.
11. Sayal K, Tischler V, Coope C, Robotham S, Ashworth M, Day C, et al. Parental help-seeking in primary care for child and adolescent mental health concerns: qualitative study. *Br J Psychiatry* 2010;197(6):476-81.
12. Tompsett H, Ashworth M, Atkins C, Bell L, Gallagher A, Morgan M, et al. *The child, the family and the GP: tensions and conflicts of interest for GPs in safeguarding*

children May 2006-October 2008. Final report February 2010. London: Kingston University, 2010

There were an addition two unpublished studies: one by myself and one by the Well Centre, London (see Table A.6.7.1 for more details).

Table A6.1: Characteristics and results of included studies

Author, publication date, country and study aim	Study population and methods	Results relating to GPs		Results relating to other professionals
		Positive	Negative	
Vulnerable populations				
Qualitative				
Boddy, 2012 England[14] Aim: evaluation of health-related work by family intervention services (FIS).	Interviews in 2007-9 with 40 parents and young people from 20 families in 4 areas of England. Families had multiple problems, including drug and alcohol use, domestic violence, extreme poverty, criminality or anti-social behaviour. Interviews conducted soon after families finished the intervention and again seven months later. FIS tried to address unmet health needs, difficulty in engaging with/ accessing health services, and capacity to manage chronic health difficulties.	GPs facilitated quick access to secondary care services.	Primary care was very difficult to access, GPs were perceived to be dismissive and not to listen. No accounts of a supportive relationship between families and GPs.	Mixed accounts of social workers: criticism about high turnover, lack of sensitivity and/or resources but also accounts of positive relationships and reliable and helpful social workers.

Table continued overleaf

Table A6.1 *Continued*: characteristics and results of included studies

Author, publication date, country and study aim	Study population and methods	Results relating to GPs		Results relating to other professionals
		Positive	Negative	
Cameron, 2007 England[15] Aim: To compare experiences of care leavers with young people who have had difficulties (but no care).	Interviews in 2003-6 with 80 care leavers aged 17-24y from 13 'leaving care teams' in England and 59 young people aged 16-29 'in difficulty' (e.g. homeless, addiction problems, a criminal record) from housing and advice support services in 4 areas in England. Participants had multiple and above average health needs. 53 participants were aged 18 or under.	GP was (by far) the most frequently mentioned health care contact for both groups and most care leavers (90%) and those in difficulty (68%) were registered. 9% of care leavers nominated their GP as the most helpful services which was high compared to many other services (2% of those 'in difficulty' rated GP the most helpful).	Experiences of GP services were highly variable. 4% of care leavers nominated their GP as the least helpful service (14% of those 'in difficulty'). GPs described as as medically incompetent, lacking social skills, with their own agenda (not listening), rushing patients and too focussed on prescribing.	All-round holistic services (e.g, 'one-stop shops' or leaving care services) were valued more than services designed to meet one type of need e.g.health services or housing services. Aside from one-stop shops, care-leavers nominated GP services the most helpful service (but not seen as so helpful by those 'in difficulty').

Table continued overleaf

Table A6.1 *Continued*: characteristics and results of included studies

Author, publication date, country and study aim	Study methods	Results relating to GPs		Results relating to other professionals
		Positive	Negative	
Chase 2008[16] England To explore wellbeing and mental health in unaccompanied asylum-seeking children and young people.	Interviews in 2006 with 54 children and young people aged 11-23y seeking asylum on their own in the UK. All lived in London.	GPs helpful in accessing secondary care or counselling.	Large variation in quality of general practice. Widespread lack of expertise/ and knowledge of the specific needs of asylum seeking young people. Participants reported an unhelpful emphasis on prescribing.	Mixed accounts of interactions with social workers including trusting relationships but also a lack of sensitivity or consistency and fairness of resource allocation. Negative account of hospital doctors as rude and insensitive.

Table continued overleaf

Table A6.1 *Continued*: characteristics and results of included studies

Author, publication date, country and study aim	Study methods	Results relating to GPs		Results relating to other professionals
		Positive	Negative	
Cossar, 2013[17] England	Content analysis of an online peer support site where young people post and respond to problems involving abuse and neglect (261 threads). Interviews in 2010-11 with 30 young people aged 11-20y, identified as vulnerable by practitioners working with them. Six focus groups with children and young people (general population), parents and practitioners in 2010-11.	When asked about where they would turn to help a neighbour's child, most parents were reluctant to go to children's social care and said they would turn instead to schools, the police or their GP.	Unlike other professionals, doctors were largely absent from online posts. The doctor's role was viewed as 'medical' e.g. attending to injuries from physical abuse.	Police were also seen to have a one-dimensional role (to stop the maltreatment) while teachers, social workers and youth workers were viewed in a more holistic way.

Table A6.1 *Continued*: characteristics and results of included studies

Author, publication date, country and study aim	Study methods	Results relating to GPs		Results relating to other professionals
		Positive	Negative	
Sayal, 2010[18] England. Aim: To explore factors influencing help-seeking behaviour.	8 focus groups with 34 parents of children aged 2-17y who lived in South London and who were concerned about their child's emotional health or behaviour (but child not currently receiving services from specialist mental health services (CAMHS)). 52% of parents were from black or minority ethnic groups and 59% were single, separated or divorced. Date of focus groups not given.	Parents reported that their GP had been concerned, helpful and sympathetic when they raised their worries about their child. Parents described GPs who were passionate about their work, especially about child health. Parents who had experienced continuity of care often trusted their GP and the GP's previous decisions.	GP's role seen as 'medical'. Parents who sought GP help saw their child's problems as health-related. Parents felt concerns were not taken seriously and that their GP had not listened and was not interested, partly because time was too short. Parents feared stigmatising labels and removal of their child.	Mixed experiences of health visitors: some parents felt they had not taken their concerns seriously whilst others saw them as helpful and sympathetic. .

Table continued overleaf

Table A6.1 *Continued*: characteristics and results of included studies

Author, publication date, country and study aim	Study methods	Results relating to GPs		Results relating to other professionals
		Positive	Negative	
Tompsett, 2010[19] England. Aim: To explore tensions and conflicts of interest for GPs in child safeguarding.	Focus group with 12 young people aged 17-20y who had been looked after, 4 of whom were also parents and most of whom were registered at one practice. Focus group with 7 mothers under 30y, most of whom were registered at the one practice.	Two mothers reported positive experiences with their GPs, saying that they felt reassured, listened to and were not rushed. At one practice, one GP was viewed by several mothers as very good with children.	For 11/12 young people, visiting the GP was a negative experience. Participants felt that GPs didn't know them or their children well, didn't have time and didn't listen. Mothers felt GPs were too interested in prescribing. Two previously 'looked after' children saw GPs as intrusive.	Mothers felt that midwives and practice nurses knew them and their children best.

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Table A6.1 *Continued*: characteristics and results of included studies

Author, publication date, country and study aim	Study methods	Results relating to GPs		Results relating to other professionals
		Positive	Negative	
Vulnerable populations: quantitative data				
Healthwatch Warwickshire, 2013[20] Aim: to capture young people's experiences of GP services	Survey in 2013 with 185 young people aged 13-25y, completed face-to-face with researchers, on paper or online. Recruited form social media, youth clubs, community groups and groups for vulnerable populations e.g. those in care. As the relevant results related to young mothers, I classified this study as a 'vulnerable' population.		Young mothers felt patronised by GPs and that this was due to their young age rather than parenting ability.	
General population: qualitative data				
Children North East & Streetwise 2011 England.[21] Aim: to explore knowledge and attitudes health and health services.	9 focus groups (number of participants not specified) of young people 13-25y old in the Newcastle area. Research conducted by young researchers.		GPs didn't listen properly or acceptable offer solutions (too keen to prescribe or refer to counselling). Young parents felt judged.	

Table continued overleaf

Table A6.1 *Continued*: characteristics and results of included studies

Author, publication date, country and study aim	Study methods	Results relating to GPs		Results relating to other professionals
		Positive	Negative	
French 2012[22] England Aim: To assess young people's experience of visiting their GP and what they would like from this service.	Questionnaires (n=60), focus groups and interviews in 2011 with 172 young people (age not reported) in Brighton and Hove, using peer facilitators.	In the three 'case studies' young people also reported having seen GPs who did not make them feel rushed, empathised, understood them and made appropriate referrals.	Young people did not feel respected but that GPs viewed them as stereotypical youth. Some felt GPs were only interested in 'medical problems'. Many felt GPs had been patronizing, judgmental, difficult to understand, and keen prescribe and get them out the door (high variability according to individual GP).	Practice nurses were frequently seen as more caring and having a more comfortable way of interacting with young people

Table continued overleaf

Table A6.1 *Continued*: characteristics and results of included studies

Author, publication date, country and study aim	Study methods	Results relating to GPs		Results relating to other professionals
		Positive	Negative	
Woodman, unpublished England. Aim: To explore young people's views of GPs' role for children and young people with social problems.	Consultation in 2012 using two small discussion groups with 8 young people aged 15-18y who were taking part in the NCB PEAR project, which supported young people's involvement in public health research. Young people were asked about their experiences of GPs and asked what they thought the GP should do in some case studies of young people with social/family problems.	There were a few young people who felt they could turn to their GP.	Many felt uneasy at the GP, anticipating judgement. GPs described as not youth friendly, blunt, not listening, disbelieving young people and intrusive.	
General Population: quantitative data				
Action for Children, 2013[23] England and N. Ireland Aim: To explore parental actions for unwell children.	An online survey with a representative weighted sample of 2,000 parents and guardians from England and Northern Ireland.	82% rated GPs as the most trusted professional for child's health. 85% GPs as "very/quite helpful".		Compared to other professionals, GPs were the most frequently used, understood and trusted source of advice and help for sick children.

Table continued overleaf

Table A6.1 *Continued*: characteristics and results of included studies

Author, publication date, country and study aim	Study methods	Results relating to GPs		Results relating to other professionals
		Positive	Negative	
General Population: quantitative data				
Balding and Regis 2012[24] UK Aim: To understand school pupils' health and related behaviour and attitudes.	Survey of over 31,000 pupils aged 10-15y from UK schools.	Most children reported feeling comfortable during their last visit to the GP (see right).	20% & 22% of girls aged 12-13y and 15-16y, respectively reported feeling 'quite' or 'very' 'uneasy' during their last visit to the GP. The same figure was lower for boys (15% and 16%, respectively).	
French 2012[22] England Aim: see above	See above	52% young people reported they were comfortable talking to their GP about mental and emotional issues.	36% reported feeling uncomfortable talking to their GP and 12% answered 'unsure'	

Table continued overleaf

Table A6.1 *Continued*: characteristics and results of included studies

Author, publication date, country and study aim	Study methods	Results relating to GPs		Results relating to other professionals
		Positive	Negative	
NCB, 2012[25] England Aim: To gain teenagers' views on health and health services	Online survey of 263 young people aged 11-19y who were members of NCB and/or b-live (online service aiming to support young people)..	48% would talk to their GP if they were worried about their health.	Most were comfortable visiting their GP but over a quarter (N=77) said they were not; they felt embarrassed (60%), found it hard to explain their problem (53%), were judged (42%), and did not understand the doctor (36%).	
Well-centre 2013, unpublished	Evaluation of Well- Centre in 2013 using 139 aged 13-30y who attended the centre. The Well-Centre is a youth health centre staffed in London by GP (adolescent health experienced), 2 youth workers and CAMHS nurse. Young people can drop in or have booked appointment. Service continues to be developed in collaboration with young people.	98% felt welcomed. 96% would recommend it and would return. 93% got what they wanted from the visit.		

Table A6.2: Overview of existing literature reviews

Review	Aim and methods*	Relevant conclusions	Overlap with my review**
Hagell, 2013[7]	Aim: to get a full picture of the UK's adolescents Methods: Collected sources which had a significant sample size (generalizable), used reliable and valid instruments and met ethical standards. Methods: not clear. Not systematic.	It is important for GP services to be youth friendly	Balding and Regis 2012[24]
Clements, 2012[8]	Aim: to examine the available evidence on how well general practice is delivering for children and young people, including experiences of the services and challenges in access.Methods: not clear. Not systematic	It is essential that young people feel they will be treated with respect and taken seriously when they go to the GP. GP surgeries should be more youth friendly in terms of booking, waiting areas and hours.	Cameron, 2007[15] Chase, 2008[16] NCB, 2012[25]
Hargreaves, 2012[9]	Aim: to investigate what data are available on the NHS experience of children and young people (0–24 years), and how their experience compares with that of older patients. Methods: Review of 38 national surveys undertaken or planned between 2001-11, identified by Department of Health. Systematic.	The voice of under 16s is not included in most national surveys. Despite high levels of overall satisfaction, young adults report a poorer experience of care than older adults. Findings support view that the 'NHS is designed by older people for older people.'	None

Table continued overleaf

Table A6.2 *Continued*: Overview of existing literature reviews

Review	Aim and methods*	Relevant conclusions	Overlap with my review**
La Valle, 2012[10]	Aim: to synthesis evidence on children and young people's views and experiences of health provision in England. Methods: Included data from England from 2007-2012. Searched data bases and gathered examples of local and national consultations with children and young people (<25y) Focussed on vulnerable groups.112 studies were included. Rapid evidence review. Not systematic.	High levels of satisfaction with some aspects of health services but young people rated their experience less positively than older NHS users. Primary, secondary and mental health staff were sometimes reported to be unfriendly and not respectful but also nice, helpful, kind, comforting and caring. Children and young people value trust and mutual respect and it is especially important for those with chronic conditions or mental health problems.	Cameron, 2007[15] Chase, 2008[16]
Lavis, 2010[11]	Aim: to draw together research on children and young people's views and experiences of mental health services. Methods: Not clear. Not systematic.	Young people feel they are treated differently because of their age. They feel GPs are lacking in understanding, awareness, empathy, and interest and are reluctant to offer support. Young people feel hospital staff can treat them as 'time-wasters'.	None

Table continued overleaf

Table A6.2 *Continued*: Overview of existing literature reviews

Review	Aim and methods*	Relevant conclusions	Overlap with my review**
Robinson, 2010[12]	Aim: to collate children and young people's views about what they want from health professionals in England. Methods: Included data from England published 2000-2009 on children and young people <25y. Searched databases, websites, and journals. 31 studies included, inductively analysed and grouped into themes. Systematic.	Children and young people want their health professionals to be familiar, accessible and available; to be informed and competent; to provide accessible information; to be good communicators; to participate in care; to ensure privacy and confidentiality; and to demonstrate acceptance and empathy. Health professionals often seem to fall short of these standards though the picture is not universally poor.	None
Freak, 2007[13]	Aim: To gain young people's views on 'helping' health professionals Methods: Included international data before 2004 on children aged 12-19y. 54 qualitative studies included.	Young people want their healthcare providers to maintain confidentiality, explain carefully, listen, be sympathetic and understanding, have mutual trust, be competent and experienced, not to patronize or judge them and to treat them as an individual and not as 'just another patient'. They also want to see the same person and, for girls, to see a female doctor for some problems.	None
*Systematic = search strategy reported, attempts to be comprehensive and appraises quality of included studies.			
**Studies included in the existing literature review *and* in Table 1 and 2 above			

Limitations of the data included in the literature review

Due to the age ranges of participants in the included studies, my results relate to secondary school aged children, young people and parents. It is likely that responding to younger children will present different issues in general practice and we should be cautious in generalising my findings to younger age groups. With the exception of the study by Balding and Regis which sampled a large and captive population of school students,[24] none of the study samples can be considered representative either of the vulnerable population of interest or of the general population. There were few efforts to achieve representativeness and by dint of participation, participants were a self-selecting group who were perhaps more likely to attempt to engage with services and view them differently to their peers. In addition, variability in patient experiences of general practice are likely to be driven by practice characteristics, such as size, availability or resources and specialist interests of the GPs working there as well as characteristics of the registered patients in each practice such as deprivation and age. Information about practice and list characteristics were not reported in the studies and we do not know whether there were consistent differences in the experiences and views of children, young people and parents in (for example) rural compared to urban practices or practices with a large proportion of children and families and those with a higher proportion of elderly patients.

Studies based on questionnaires provide very limited insight into views and experiences and it is very difficult to attribute views to the GP-patient relationship: young people may feel uncomfortable due to their experience of the reception/waiting area of the surgery, for example.[22] We have focussed on the GP-patient relationship but a large proportion of patient contact will be with other members of the primary healthcare team (practice nurses, health visitors or nursery nurses). As only one questionnaire study used a validated survey tool,[24] we do not know whether the surveys were actually measuring what they aimed to measure. The qualitative samples, which provided the richest accounts of views and experiences, were necessarily small. These types of studies can provide hypotheses about the types of

experiences that parents, young people and children may have but they cannot quantify how common they are across the population.

APPENDIX 7: Supplementary material for Chapter 7

There is no supplementary information for Chapter 7

APPENDIX 8: Supplementary material for Chapter 8

There is no supplementary information for Chapter 8

APPENDIX 9: Published papers from my PhD study

This appendix originally reproduced six published papers based on work undertaken for my PhD. I have removed this appendix for the print version in order to respect copyright of the journals. The papers were originally reproduced in the following order:

1. Gilbert R, Woodman J, Logan S. Developing services for a public health approach to child maltreatment. *International Journal of Children's Rights* 2012;20(3):323-42.
2. Tariq S, Woodman J. Using mixed methods in health research. *JRSM Short Reports* 2013;4(6).
3. Woodman J, Allister J, Rafi I, de Lusignan S, Belsey J, Petersen I, et al. Simple approaches to improve recording of concerns about child maltreatment in primary care records: developing a quality improvement intervention. *Br J Gen Pract* 2012;62(600):e478-e86(9).
4. Woodman J, Freemantle N, Allister J, de Lusignan S, Gilbert R, Petersen I. Variation in recorded child maltreatment concerns in UK primary care records: a cohort study using The Health Improvement Network (THIN) database. *PLOS ONE* 2012;7(11):1-9.
5. Woodman J, Gilbert R, Allister J, Glaser D, Brandon M. Responses to concerns about child maltreatment: a qualitative study of GPs in England. *BMJ Open* 2013;3(12):e003894. doi: 10.1136/bmjopen-2013-94.
6. Woodman J, Brandon M, Glaser D, Gilbert R. Patterns of health service use and child abuse or neglect in young childhood: a systematic review. *Archives of Disease in Childhood* 2011;96(Suppl 1):A94-A95.

APPENDIX 10: Presentations and posters arising from PhD study

Presentations

- September 2012 Primary care safeguarding forum conference (Peterborough) "Maltreatment-related concerns recorded in children's primary care health records."
- July 2012 THIN user group (London) seminar "Maltreatment-related concerns recorded in children's primary care health records."
- April 2012 Bascpan conference (Belfast) "Child maltreatment-related concerns recorded in UK primary care: a study using the THIN database."
- April 2012 Bascpan conference (Belfast) "GP's perspectives on children with concerns about (possible) maltreatment."
- July 2011 PRIMENT seminar (London) "Using THIN before a trial:GP responses to child abuse and neglect."
- December 2011 UCL-Institute of Child Heath child maltreatment working group seminar (London) "Clinicians views of their role in responding to child maltreatment in primary care."
- May 2010 UCL-Institute of Child Health seminar (London) "Conducting mixed methods research."

Posters

- "Recording of child maltreatment in primary care: a mixed method approach", Primary care database symposium, London January 2012.
- "Recording of child maltreatment a study using The Health Improvement Network (THIN) database", UCL e-health conference, London November 2011.

- “Recording of child maltreatment in primary care: a study using The Health Improvement Network (THIN) database”, Society of Academic Primary Care, Bristol July 2011.

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25. National Children's Bureau. *Teenagers' views on their health and local health services*. London: NCB, 2012.